

A MEASURE OF THE ÉLITE: A HISTORY OF
MEDICAL PRACTITIONERS IN HARLEY STREET,

1845-1914

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Thesis Abstract

Though Harley Street has been viewed as the provenance of the medical élite in Britain, no attempt has been made to systematically examine this élite in its historical context or to consider the veracity of this view. Hence, this thesis reconstructs the totality of all the male ($n = 657$) and female ($n = 24$) medical practitioners who arrived in Harley Street from 1845-1914 by undertaking a prosopographical analysis and contextualising the historical background in which they lived and worked. Over the course of the nineteenth century, Harley Street became a progressively more fashionable choice for medical practitioners wishing to establish a practice in London and in most cases, this address represented the pinnacle of their career trajectory. It is argued here that an élite medical enclave did, indeed, establish itself in this geographical area during the period. The group's reputation was assessed through their medical qualifications, scholarships, prizes, teaching and hospital posts, publications, public lectures and their role in medical societies.

Harley Street medical practitioners differed from other London medical practitioners because they published more material (85 of the cohort in general and 93 percent of the cohort who qualified MD published their work, in contrast to up to 50 per cent of London medical practitioners), had more prestigious qualifications (86 per cent were qualified MD, MB, FRCP, FRCS or MRCP in contrast to approximately 25 per cent in Greater London), were members of medical societies (almost 90 per cent of the cohort in contrast to between 40 and 50 per cent of GPs in Britain), created new

medical specialities, established specialist hospitals, took prominent roles in medical societies and delivered renowned public lectures that were published in the main medical journals. Moreover, this group wielded considerable collective editorial control in a wide range of medical publications. Hence, their efforts greatly facilitated the professionalisation of medicine in the late nineteenth and early twentieth centuries. Through their senior hospital and teaching posts the cohort had an important influence on the next generation of medical practitioners, as these connections were crucial in attracting new medical practitioners to the Street. This thesis, therefore, determines whether Harley Street can be regarded as a measure of the medical élite.

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List of Abbreviations

BA	Batchelor of Arts
BAO	Batchelor of Obstetrics
BC., B. Ch., BS	Batchelor of Surgery
BMA	British Medical Association
<i>BMJ</i>	British Medical Journal
CM., MS	Master of Surgery
DNB	Dictionary of National Biography
DPH	Diploma in Public Health
FRCP	Fellow of the Royal College of Physicians
FRCS	Fellow of the Royal College of Surgeons
FRS	Fellow Royal Society
GMC	General Council of Medical Education and Registration of the United Kingdom
LAH	Licentiate Apothecaries Hall, Ireland.
LKQCPI	Licence of King's and Queen's College of Physicians of Ireland
LRCP	Licentiate of the Royal College of Physicians
LSA	Licentiate of the Society of Apothecaries
LSMW	London School of Medicine for Women
L (RFH) SMW	London (Royal Free Hospital) School of Medicine for Women
MD	Doctor of Medicine

MOH	Medical Officer of Health
MFW	Medical Women's Federation
MRCP	Member of the Royal College of Physicians
MRCS	Member of the Royal College of Surgeons
NHW	New Hospital for Women
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
RFHSM PC	Royal Free Hospital School of Medicine Press Cuttings
Wellcome	Wellcome Library for the History and Understanding of Medicine

CHAPTER 1

Introduction

The Harley Street Area has long been a major centre of medical activity in Britain. Known locally as *The Valley of the Shadow of Death* or *Pill Island*, the doctors and surgeons who practice there are considered to be among the very best in their area of expertise.¹ By the end of the twentieth century there were over 1,400 registered doctors, dentists and surgeons working in the Harley Street Area in one year alone, offering a variety of specialities plus support staff of some 3,000.² A survey undertaken by the health care analysts, HCIS, in 1995, estimated that private medical care in the area was worth £375 million, while London's total health care market was said to be £650 million.³ The Harley Street Area accounts for more than 60 per cent of this market. Though much of the scholarship on Harley Street portrays its medical practitioners as being synonymous with medical pre-eminence, no attempt has yet been made to systematically examine their élite status.⁴ For example, 31 out of the total 171 members of the Council of the RCS

¹ Some black cab drivers in London refer to Harley Street as the valley of the shadow of death whilst Estate agents refer to the area as Pill Island see, Paul Ferris, *The Doctors*, (London, 1965), p. 25.

² Anon, *The Marylebone Journal*, 17, Winter 1998, p. 11. Dr Thomas Stuttaford, 'Cashing in at Harley St.', *The Times*, November 19, 1998, p. 22, stated that the doctors and dentists in practice in Harley Street had combined earnings of approximately £138 million.

³ *Ibid.*

⁴ For examples, see Reginald Pound, *Harley Street*, (London, 1967), *passim*, Mrs Alec. Tweedie, (ed.) *George Harley F.R.S. or the Life of a London Physician*, (London, 1899), p. 133, William Byam, *The Road to Harley Street*, (London, 1963), p. 227. M. Jeanne Peterson discusses the 'Formation of a Professional Elite' in Chapter 4 of *The Medical Profession in Mid-Victorian London*, (London, 1978), pp. 136-194, however, there is no reference to Harley Street.

between 1845-1945 were Harley Street men.⁵ Despite its prestige, prominence and international reputation there has been no critical or rigorous analysis of the development or inner working of the Street.

This thesis, therefore, aims to correct this lacuna in the historical literature and is a study of all the medical practitioners who arrived in Harley Street from 1845 to 1914, which comprised a total of 657 men and 24 women. These two dates were selected because the *London and Provincial Medical Directory* was first published in 1845 and the onset of the First World War inevitably changed the ambience and the day-to-day workings of these great family houses; moreover, the large number of staff needed to run them could no longer be sustained.⁶ The habit of multiple lettings that had taken off in the 1890s increased sharply from the start of the war. The system whereby a consultant hired a room with secretarial support, whilst maintaining a family home elsewhere became firmly established in the inter-war period and this system has been used ever since.

Though Harley Street has become synonymous with those streets that surround it and refers equally to Wimpole, Queen Anne and Devonshire Streets, throughout the thesis “Harley Street” will refer strictly to the Street itself, whereas the streets bordering it will be referred to as the

⁵ Zachary Cope, *The History of The Royal College of Surgeons of England*, (London, 1959), pp. 318-319 and 342-344. Andrew Morrice in ‘Honour and interests: Medical Ethics in Britain, and the work of the British Medical Association’s Central Ethical Committee, 1902-1939’, (MD thesis, University of London, 1999), p. 344, maintained, that the council of the GMC was composed of “36 members of the elite” of the profession, which were drawn from the licensing bodies in addition to persons nominated by the monarch and a number of these were Harley Street men.

⁶ Pound, *Harley Street*, p. 99, by the 1920s Pound argued, few houses were family homes. In 1958, 940 medical practitioners practiced in Harley Street and as there were only 144 houses in the street, multiple letting was common. See also Juanita Burnby, *Caricatures and Comments*, (Staines, 1989), p.19.

“Harley Street Area”. A recent map of the Harley Street Area is shown in Plate 1.1.⁷ The Marylebone Road to the north and Oxford Street to the south, hem in this medical district.⁸ Marylebone High Street forms a border to the west and Portland Place delineates its boundary to the east. The red line shows the boundaries of the Howard de Walden Estate who have owned the freehold of these houses since 1889. The Crown is the main freeholder of the properties on Harley Street, which fall outside the red line.

⁷ Map on the Harley Street Area was in an Information Pack on the area available from the Howard de Walden Estates Limited.

⁸ Upper Harley Street, recently renamed Brunswick Street lies to the north of the Marylebone Road.

Plate 1.1, Map of the Harley Street Area

Image removed due to third party copyright

The *Medical Directory* contains the first comprehensive listing of medical practitioners by registered address in Britain and includes a brief biography relating to their profession. Apart from the short-lived *Medical Registers*, which were published in 1779, 1780 and 1783, the only other source materials available were the eighteenth and nineteenth century trade directories, which provided the address of a person's practice.⁹ These directories were not used in the database, as they did not list all addresses nor were they published annually. Moreover, in 1845 there were only eight medical practitioners registered in Harley Street.

The Parameters of the Thesis

Since the aim of this thesis was to reconstruct the totality of Harley Street medical practitioners from 1845-1914, a prosopographical analysis was undertaken using the total population who practised in the Street. Whilst various statistical sampling measures were considered, systematic random sampling procedures were eliminated, because it was not possible to construct a list in which a systematic sample could be taken to represent all the medical practitioners in Harley Street, especially since not all of them had an obituary published in the main medical journals.¹⁰ If this method had been used, it would have skewed the data and produced unreliable results. The dates of death were available for only 50.37 per cent (343 out of

⁹ Anon, *The Medical Register for the Year 1779*, (London, 1779), Anon, *The Medical Register for the Year 1780*, (London, 1780), Anon, *The Medical Register for the Year 1783*, (London, 1783).

¹⁰ A random sample has been defined by George A. Ferguson as "one such that every member of the population has an *equal* [italics mine] probability of being included in it see, George A. Ferguson, *Statistical Analysis in Psychology and Education*, (New York, 1981), pp. 143-44.

681) of the cohort and this was not evenly spread throughout the period covered by the thesis, thus this sample would not have been representative of the group.¹¹ As the statistician, George Ferguson cautioned, “on occasion, samples are drawn from lists which do not provide a complete record of the members of the population, but are viewed, perhaps erroneously, as representative of the population”.¹² Sorting the group alphabetically or chronologically and then selecting a sample of, say, every tenth man or every new decade would also not have been an adequate representation of the cohort. Having a complete data set of this population made it possible to present findings and discussions with empirical confidence about the cohort, thus avoiding generalisations about the group based on a number of isolated studies.

To make comparisons with two other groups of medically qualified individuals in London, material was obtained from the *Medical Directory* for those who practiced in the Harley Street Area and for those who set up practice throughout other areas in London for the years 1845, 1880 and 1914. These years were selected because they correspond to the start, middle and end dates of the thesis. The geographic area for those examined in London extended as far north as Enfield, as far south as Lewisham, as far east as Woodford and as far west as Shepherds Bush; hereafter, referred to as Greater London. A systematic random sample of 601 medical practitioners who worked throughout the whole of Greater London was

¹¹ Dates of death were available for 343 and dates of birth available for 389, the dates of birth and death together were available for 308 of the cohort.

¹² Ferguson, *Statistical Analysis*, p. 144.

undertaken. To obtain this sample, ten percent of male medical practitioners were selected from the *Medical Directory* for 1845 and 1880. As the population for 1914 was more than twice the size of 1845 and 1880 ten per cent would have doubled the sample size, instead, five per cent of the population was selected. The process involved selecting every 10th (for 1845 and 1880) or 20th person (for 1914), but if an entry only contained a name with no address or qualifications, or if the entry were a woman, these individuals were not used and instead the next person was included in the sample.

The entire population of medical men practicing in the Harley Street Area yielded a population size of 478. Since this was a smaller subset of the entire population, it was too small to warrant taking a random sample. The geographic region for those in the Harley Street Area included those streets parallel and perpendicular to Harley Street such as Wimpole Street, Devonshire Street, Welbeck Street, and etc., (see Map on page 13). Table 1.1 Appendix A shows the total population and sample sizes of these groups over the three selected years.

Composition of the Chapters

The thesis is divided into two main sections; the first section comprises Chapters One and Two. Chapter One elucidates the methodology employed in selecting the Harley Street cohort and outlines the status of the medical profession in Victorian Britain. The historiography of Harley Street is also examined and consideration is given to the major advances in medicine that took place from 1845 to 1914. Chapter Two discusses the birth of the

medical elysium and the topographical background from which Harley Street emerged as a medical district. It also addresses the growth and popularity of the Street as a medical area up to the start of the First World War. Topics that fall outside the prosopographical analysis, such as the motivation behind the cohort's selection of Harley Street as a practice address, were discussed. The social aspect of Harley Street, which included the cohort's appearance, their use of leisure time was also determined. Finally, those who managed to attain the pinnacle of social and professional success, by becoming the court physicians and surgeons were identified. The second section of the thesis includes Chapters Three to Seven and is largely a prosopographical examination of the Harley Street male and female cohort and an assessment of their prominence in the medical profession.

Chapter Three considers whether the Harley Street group were part of an educated or academic *élite*. Medical qualifications earned by the cohort were analysed to establish the academic calibre of the group. The results were compared to those from the Harley Street Area and to the sample from Greater London for the years, 1845, 1880 and 1914. Indicators of academic pre eminence such as prizes, scholarships, and endowments awarded to the Harley Street group were examined and the findings were evaluated against the Harley Street Area and Greater London sample. Finally, the medical school in which the cohort gained their medical training and the place of their post graduate study was assessed to test the group's homogeneity and the extent of their post graduate experience.

Chapter Four examines the variety and eminence of the cohort's hospital posts and the degree of specialisation in a particular branch of medicine or surgery. It will be argued that these medical practitioners not only elevated their status to the rising professional class in Victorian England, but that they facilitated the professionalisation of specialised branches of medicine, which may have, in turn, helped to promote the professionalisation of medicine in Britain.

Chapters Five and Six together explore the means of professional advancement and the development of the cohort's medical knowledge *vis-à-vis* post-medical qualifications. Memberships of medical societies, invitations to speak at public lectures and publications by the cohort were analysed to shed light on these matters. Of particular interest were the following: the methods Harley Street men used to stay informed about advances in medicine, the means by which they disseminated the results of their work — either through medical publications, textbooks or monographs — and their prominence in communicating their medical or surgical knowledge to the rest of the medical community, through memorial orations or lectures.

Chapter Five considers eponymous or memorial lectures and public orations on medical topics given by the group.¹³ It examines the extent and variety of these lectures and evaluates their significance within the medical

¹³ Other societies such as the BMA also held annual lectures. In the BMA's case these were an Address in Medicine and an Address in Surgery. See for example, the Anon, 'The British Medical Association: The Address in Medicine', *Lancet*, Aug. 3, 1901, pp. 294-95. The above analysis, however, is confined to eponymous lectures.

arena. Lectures and public orations were one of the most prominent displays of success, experience and medical knowledge within the profession. They were a platform from which those who flourished academically or were eminent in their field could impart their knowledge to the rest of the medical profession. Yet, despite their significance, historians of medicine have failed to systematically examine their role.¹⁴

It is being argued that lectures were a valuable form of self-promotion for the group: announcements of forthcoming important memorial lectures such as the Harveian Oration and the Gulstonian and Croonian Lectures were printed in broad sheet newspapers such as the *Times* and medical press including the *BMJ* and the *Lancet*, in addition to other specialist journals where relevant, such as *Brain* or *Ophthalmic Review*; thus, providing the opportunity for the speaker to gain recognition in his field.¹⁵

Occasionally, contemporaries commented on the originality of the subject matter or scholarly nature of the paper. New methods or theories were often eagerly awaited. When Dr. Barnes proposed his Lettsomian Lectures on "The Physiology and Treatment of Flooding from Unnatural Position of the Placenta" the *Lancet* remarked that "the able lecturer is

¹⁴ For a list of endowed lectures and bequests see William Munk, *The Roll of the Royal College of Physicians*, 2nd edition, Vol. III, 1801 to 1825, (Pall Mall East, 1878), Zachary Cope, *The History of The Royal College of Surgeons of England* (London, 1959) and G.H. Brown, *The Lives of the Fellows of the Royal College of Physicians of London*, 1826-1955, (London, 1955).

¹⁵ See for example, Anon, 'Meeting of Societies During the Next Week', *BMJ*, Feb. 24, 1866, p. 218 and Anon, 'Royal College of Physicians of London', *Lancet*, Aug. 9, 1902, p. 596.

understood to have arrived at some new views on this important subject, his exposition is looked for with considerable interest.”¹⁶

The cohort’s publications are analysed in Chapter Six. It will be argued that medical publications played a fundamental part in the diffusion of medical knowledge, new ideas and the results of clinical investigation for the medical practitioners in Harley Street. Most of the major medical societies published their transactions in ancillary medical journals and their meetings were frequently “reported, often fully, in the *Lancet* and *British Medical Journal*, so providing valuable publicity for the aspiring consultant.”¹⁷ Data collected on the entire Harley Street group who had published material in the *BMJ*, the *Lancet* and various specialist medical journals were analysed to ascertain how prodigious the cohort were as a group and to determine the prominence attained by those who had published. Medical journals founded or edited by the cohort were investigated to determine the editorial authority of the cohort. Other printed material such as hospital reports, manuals, dictionaries and books edited by the group corroborated the view that Harley Street medical practitioners were leading authorities in their area of expertise and published frequently.

Chapter Seven examines the lives and careers of women medical practitioners who became established in Harley Street before the First World War. It will be argued that the acquisition of consulting rooms in

¹⁶ Anon, ‘The Lettsomian Lectures’, *Lancet*, Apr. 18, 1857, p. 416.

¹⁷ A. M. Cooke, *Sir E. Farquhar Buzzard, Bt. K.C.V.O., D.M., F.R.C.P. An Appreciation* (London, 1975), p. 11.

Harley Street not only represented the apex of achievement in private practice for men, but that a number of women also shared that aspiration. Since this thesis examines the medical practitioners in the Street, women who worked in ancillary medical services such as nursing or midwifery are not included.¹⁸ Despite the claims of Jeanne Peterson that, “few women managed to enter the profession during the Victorian era” and since virtually all of the scholarship on Harley Street has portrayed it as a male bastion, there has been no attempt to assess the position of female medical practitioners within it.¹⁹ Thus, these conventional views have completely neglected the vital contribution that Harley Street women made to the practice of medicine and the inspiration they provided for the next generation of women medical practitioners.

It will be shown that there were, indeed, a number of female medical practitioners on Harley Street. Whilst Mary Ann Dacomb Scharlieb became the first qualified female medical practitioner in 1888 to establish a practice there, by 1914, 24 women had established a practice in the Street.²⁰ Despite their small number, their entrance into the élite male enclave of Harley Street is of interest to the medical historian. To assess their professional

¹⁸ For a history of Florence Nightingale and her nursing school in Harley Street, see H. Verney, ed. *Florence Nightingale in Harley Street*, (London, 1970).

¹⁹ Pound, *Harley Street, passim*, William Evans, *Journey to Harley Street*, (London, 1968) and R. Scott Stevenson, *Goodbye to Harley Street*, (London, 1954), do not mention women medical practitioners in Harley Street at all. Harvey Graham, *A Doctor's London*, (London, 1952), makes a short reference to Elizabeth Garrett Anderson only. Cyril Phillips Bryan, *Roundabout Harley Street: The Story of Some Famous Streets*, (London, 1932), devotes a chapter (xv, pp. 111-118) to Queen's College for Women (1848). Although Bryan discusses early 'pioneers' no reference is made to the female medical practitioners in Harley Street. Peterson, *Medical Profession*, p. 2.

²⁰ J. & A. Churchill, *The London and Provincial Medical Directory for England and Wales*, (London), Vols. 1888-1914.

standing, the qualifications, training, professional life and working relationships of the female cohort were examined and analysed to determine whether a commonalty existed among these medical women in Harley Street.

Sources and Evidence

The primary sources used in this thesis were collected to create a database, so that quantitative and qualitative methods could be used to analyse systematically the large cohort of medical practitioners. The principal sources for the construction of the database were the *Medical Directory*, the *Medical Register* and *Who's Who*; these were supplemented by diaries, archival material, autobiographies, biographies and obituaries. The *Lancet* and the *BMJ* provided 343 obituaries, which represented 50.37 per cent of the cohort. Additional information was also obtained from eighteenth century trade and street directories.

If the predominant image of Victorian biography was, according to Lytton Strachey, one of “concealment and sugar coating”, this was also largely true of Victorian obituaries.²¹ For those obituarists who went into detail (some were only a paragraph long), many eulogised their subject. Even so, few were as hagiographic as Dr Reynolds of University College, who wrote about his colleague, Professor Edmund Parkes:

White as a pillow on which his head was resting, there was more than ideal beauty in his face, for it was the real and still living clothing of the heart and mind of one whose memories of past and blameless life had given him

²¹ Quoted in Michael Shortland and Richard Yeo, eds., *Telling Lives in Science: Essays on Scientific Biography* (Cambridge, 1996), Introduction, p. 23.

perfect peace ... Pure as a sunbeam, strong as a man, tender as a woman...²²

Occasionally negative comments were made, but this was unusual.²³ The biographer's difficulties were summed up by "R.C.", the obituarist of Norman Dalton, a Harley Street physician:

only the would be biographer knows how difficult it is to breathe again the breath of life onto a dead man's self and give a fleeting resurrection to his personality. One is so apt to slip aside from the strait way of truth into the turgid eulogy of an apotheosis, or into a sterile catalogue of the material circumstances of his life, without regard to the spiritualities that make a study of the life profitable.²⁴

Obituaries were predominately written by medical colleagues who generally knew the deceased. Thus, the authors tended to concentrate on the subject's medical careers and few references were made to their schooling or interests outside medicine. Unless they were members of a distinguished family, little information was given about their personal lives.

The archives at the Howard de Walden Estates, the Royal Free Hospital, the Royal Colleges of Physicians and Surgeons, the Royal Society of Medicine and the Wellcome Trust Library were also consulted. The Howard de Walden archives hold the Rate Books, which contained details of the annual rent, and the premium paid for the Freehold. They related mainly to the twentieth century, as the earlier records were destroyed. These archives also contained correspondence files dealing with the Estate and the Leaseholders. From the late nineteenth century, the Estate worked

²² Anon, 'Professor Parkes', *Lancet*, Mar. 25, 1876, p. 481.

²³ Comments were made such as "he was not a particularly impressive teacher", see, P.R.E., 'Edward Alfred Cockayne', *Lancet*, Dec. 8, 1956, p. 1220 and in Anon, Wilfred Trotter, *BMJ*, Nov. 21, 1931, p. 969 "he was no virtuoso of the operating theatre, he was no profound scholar, he had opened up no new province of surgery", however, most negative comments were followed by a positive statement on the merits of the deceased.

²⁴ R. C., 'Norman Dalton', *BMJ*, Mar. 17, 1923, p. 490.

in agreement with the Westminster planning authority to vet newcomers rigorously.²⁵ They were crucial in the tenant selection process. Those who could not produce evidence of their qualifications were, for example, rejected. A licence was granted to “fully qualified” medical practitioners only and by the early 1920s the standard number of plates, which were 5.5 x 2.5 inches, were restricted to four per house.²⁶ Occasionally the Estate, on application, allowed five licensees to practice per house, which meant that two practitioners shared a brass plate.²⁷ A couple of houses in Harley Street in 1928 had six or more plates and the reason for such “exceptional” circumstances was that these houses had “a much larger number of rooms than usual, or in some cases, the houses do not belong to this Estate”.²⁸

The *Medical Directory* was the only source that contained a Street List of London practitioners for the period, making it possible to locate all Harley Street medical practitioners. This directory was used to determine the movement of medical practitioners into and out of Harley Street from 1845 to 1914. To evaluate the fluctuation in the number of arrivals and departures during the period, a comparison between consecutive years had

²⁵ Pound, *Harley Street*, p. 15, stated that the Howard de Walden family inherited the Estate in 1854, however, the historical evidence does not support this view. According to Charles Mosley, (ed.) *Burke's Peerage & Baronetage*, 106th edition, Vol. II, (London, c1999), pp. 2285-2288, the sixth Earl of Portland and fifth Duke of Portland, William John Cavendish Cavendish-Scott-Bentinck, died in 1879, without issue and the estate passed to his three sisters; Charlotte, Mary and Lucy, Dowager Baroness Howard de Walden. Mary died in 1874 and Charlotte died in 1889 so the full estate went to Lucy. When Lucy died in 1899 the estate passed to the seventh Baron Howard de Walden.

²⁶ Letters to Dr Sloan Chessser, from the Howard de Walden Estate, 4 Oct. and 4 Nov. 1921, Archives of the Howard de Walden Estate.

²⁷ Letters to Dr Milligan, from the Howard de Walden Estate, 16 March 1922, Archives of the Howard de Walden Estate.

²⁸ Letters to Mrs E. M. Sloan Chessser, M.D., from the Howard de Walden Estate, 17 Jan., 1928, Archives of the Howard de Walden Estate.

to be undertaken to show the total number of arrivals, incumbents and departures both annually and cumulatively and a sample of the results can be seen in Appendix A.

The Englishwoman's Year-Book was important for Chapter Seven, "The Women Doctors of Harley Street", as it was the only directory that listed registered women doctors as a separate category from 1888 to 1910.²⁹ Since this included many of the women examined in this thesis, it was a useful tool for quantitative historical analyses. The archives of the Women's Federation and the London (Royal Free Hospital) Medical School for Women were also consulted to augment the *Year-Book*.

The use of the *Medical Directory* as a Principal Source

The *Medical Directory* contained some inconsistencies, especially when the addresses in the Street List did not always correspond with those in the biographical section of the *Directory*. The biographical section lists Harold Theodore Thompson and Harry Beckett-Overy as arriving in 1906 and 1908 respectively, however, the Street List does not include them until 1908 and 1909 respectively. For these cases, the *Medical Register*, biographies and obituaries were used to ascertain whether a person was actually registered in Harley Street. In some cases, a small number of medical practitioners were still registered in the Street, although they had actually retired. For

²⁹ *Medical Directory*, Vols. 1845-1914, and *The Medical Register*, (London, from 1859 to 1914). Although, these publications contained a list of registered medical practitioners, they do not account for women separately.

example, Peyton Blakiston who retired from practice in 1871 was still listed as practising in Harley Street until 1876.³⁰

Marguerite Dupree and Anne Crowther have shown that the style of biographies in the *Medical Directory* changed over time.³¹ The medical school or university in which a person did his training, for example, was not entered in the *Directory* until the 1860s.³² For such individuals as Mary Scharlieb and Jane Walker their personal histories stated they arrived in Harley Street in a particular year, but it was not recorded in the *Directory* until the following year. However, as the date of departure was usually listed a year after they arrived, the calculation of the total number of years an incumbent was registered in the Street remains, therefore, reasonably accurate.

Inconsistent and contradictory accounts of the number of medical practitioners in Harley Street appear quite often in the scholarly literature.³³ According to Zachary Cope, there were three doctors practicing there in 1840, whereas Harvey Graham, Gordon Wolstenholme and Cyril Phillips Bryan maintain that there were six doctors in the same year.³⁴ Whilst Reginald Pound claimed that by 1873, 36 medical men had a Harley Street address, *The Medical Directory* for 1873 revealed, however, that

³⁰ Others include Violet Kelyack, Francis Bisset Hawkins, Peyton Blakiston who retired before they arrived in Harley Street.

³¹ Marguerite W. Dupree and M. Anne Crowther, 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: The *Medical Directory* as a Historical Source', *Bulletin of the History of Medicine*, Vol. 65, 1991, pp. 209-233.

³² *Ibid.*

³³ It is possible that there were some unregistered medical practitioners practising in Harley Street, however, this thesis only deals with those who were registered.

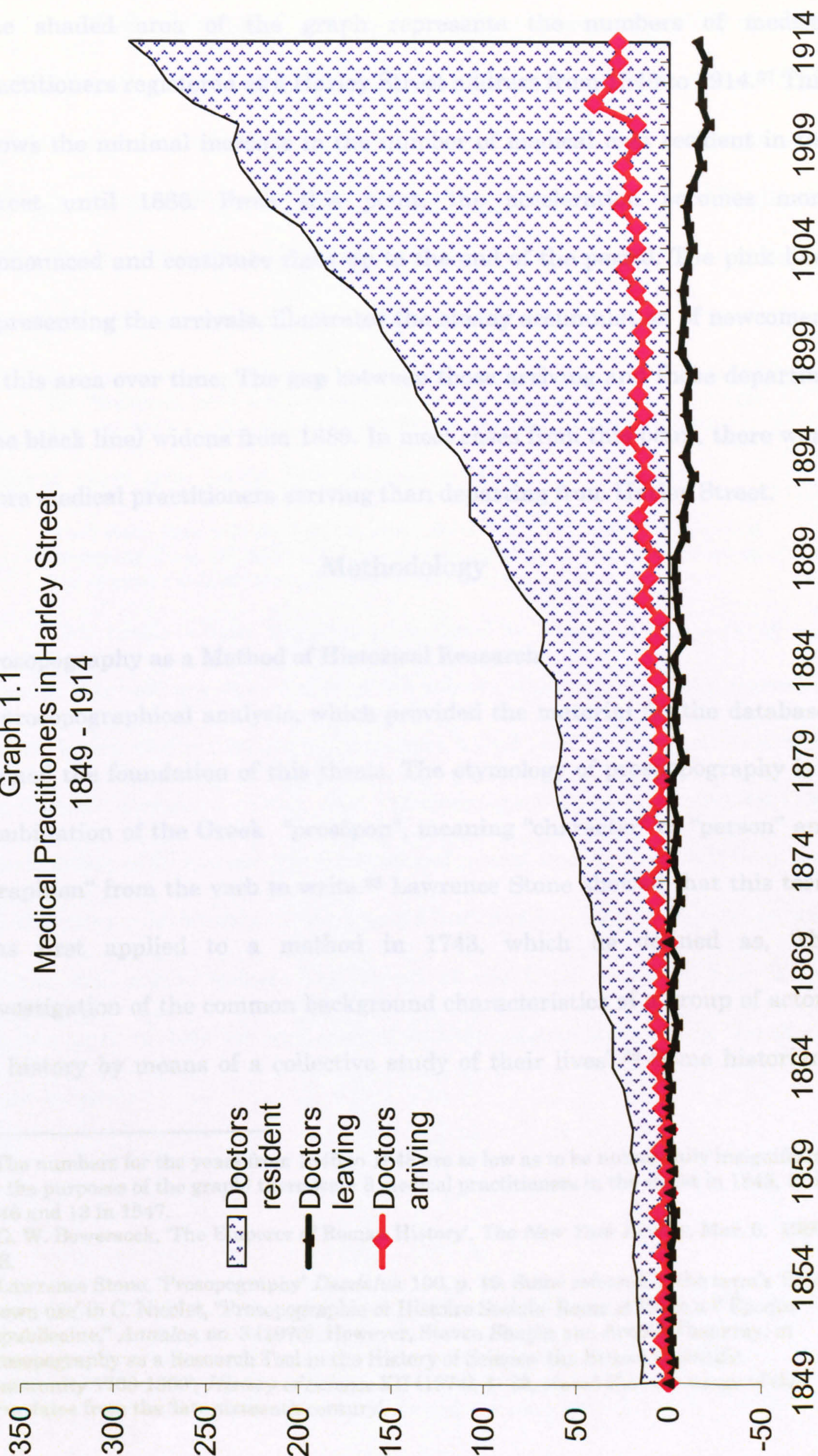
³⁴ Sir Zachary Cope, "Harley Street," *History of Medicine*, 4, 2, 1972, p. 7 and Graham, *Doctor's London*, p. 25, Gordon A. Wolstenholme, 'Harley Street Address', *Journal of the Royal Society of Medicine*, 92, 8, 1999, p. 426 and Bryan, p. 122.

there were 48 practitioners.³⁵ Although the author of Samuel Fenwick's obituary in the *BMJ* stated correctly that Fenwick commenced practice in Harley Street in 1862, he also claimed that at the time, the Street "only boasted of one other medical man among its inhabitants". Again *The Medical Directory* indicated that there were, in fact, eight medical practitioners registered in Harley Street in 1845 and by 1862 there were 37.³⁶ Tabulating and plotting the results in Graph 1.1, made it possible to examine the growth in popularity of Harley Street as a medical enclave.

³⁵ Pound, Harley Street, p. 16 and *Medical Directory*, Vol. 1873, p. 31. The names were also cross-checked to *The Medical Register*, Vol. 1873, six individuals did not appear in the *Register*: - G. Lawson, G. Gregson, G. Williams, I. B. Berkart, J. L. Clarke and F. B. Hawkins. This brings the total in Harley Street according to *The Register* to 42. This additional difference only compounds the need for a systematic collection of data.

³⁶ Anon, 'Samuel Fenwick', *BMJ*, December 27, 1902, p. 1973.

Graph 1.1
Medical Practitioners in Harley Street
1849 - 1914



The shaded area of the graph represents the numbers of medical practitioners registered at a Harley Street address from 1848 to 1914.³⁷ This shows the minimal increase in the number of medical men resident in the Street until 1886. From this point, the acceleration becomes more pronounced and continues right up to the end of the period. The pink line, representing the arrivals, illustrates the steady accumulation of newcomers to this area over time. The gap between those arriving and those departing (the black line) widens from 1889. In most cases from this point, there were more medical practitioners arriving than departing from Harley Street.

Methodology

Prosopography as a Method of Historical Research

A prosopographical analysis, which provided the material for the database, formed the foundation of this thesis. The etymology of prosopography is a combination of the Greek “prosōpon”, meaning “character” or “person” and “graphien” from the verb to write.³⁸ Lawrence Stone showed that this term was first applied to a method in 1743, which he defined as, “the investigation of the common background characteristics of a group of actors in history by means of a collective study of their lives”.³⁹ Some historians

³⁷ The numbers for the years from 1845 to 1848 are so low as to be numerically insignificant for the purposes of the graph: there were 8 medical practitioners in the street in 1845, 11 in 1846 and 13 in 1847.

³⁸ G. W. Bowersock, ‘The Emperor of Roman History’, *The New York Review*, Mar. 6. 1980, p. 8.

³⁹ Lawrence Stone, ‘Prosopography’ *Daedalus*, 100, p. 49. Stone referred to the term’s ‘first known use’ in C. Nicolet, “Prosopographie et Histoire Sociale: Rome et Italie à l’Époque Republicaine,” *Annales*, no. 3 (1970). However, Steven Shapin and Arnold Thackray, in ‘Prosopography as a Research Tool in the History of Science: the British Scientific Community 1700-1900’, *History of Science* XII (1974), 1-28, stated that the usage of the term dates from the ‘late sixteenth century’.

have described this method as a group or collective biography.⁴⁰ By the mid-twentieth century, prosopography had, however, become more sophisticated and had moved beyond the simple process of collective biographies of political or social élites analysed, by such historians as Lewis Namier. In 1970, Steven Shapin and Arnold Thackray re-defined the principles underlying the new method when they argued that:

modern prosopographical analyses is not the routine collected biography of the Victorians, but a sophisticated tool for establishing links between action and context, akin to the 'multiple career line analysis of the sociologists.'⁴¹

Some 20 years later David Allen maintained that it was also:

much more than putting together a bundle of brief life-histories: it involves combining these in the hope of uncovering evidence of shared outlooks or ties of loyalty indicative of otherwise hidden social groupings.⁴²

This thesis adopts the models outlined by Shapin and Thackray and Allen in establishing links between the cohort, which represents a summary of the Harley Street medical practitioners based on the characteristics of its constituent members. Thus, the prosopographical analysis includes an examination of (i) the group's professional, social and familial relations and (ii) the inter-relationship of the group's background, education, career, and professional achievements. The object of the basic analysis was to get similar types of data for each person so that comparisons within the group could be made.

⁴⁰ Anne Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford, 1999), p. 8.

⁴¹ Shapin and Thackray, 'Prosopography', p. 3.

⁴² David E. Allen, 'Arcana ex Multitudine: Prosopography as a Research Technique', *Archives of Natural History* (1990), 17 (3): 349-359. For a comprehensive history of the use of Prosopography as a research tool, see Shapin and Thackray, 'Prosopography', *passim*.

Building the Database

The database management system Microsoft Access was chosen because it provided a manageable system of information retrieval.⁴³ There are a number of different methods of designing a database for the historian including the *model-oriented* approach. This method was used in this thesis and necessitated mapping out possible professional and social relationships between the group and building a set of tables. These were then interpreted to allow a representation of the cohort to be determined. Biographical details including the date of birth and death, education and career, publications and society memberships were created for each individual by the use of the Access form. These details permitted the inclusion of information from obituaries, biographies and other printed sources that could not otherwise have been included on the database due to their disparate nature. Sources that were “simple, complete and regular in form” were chosen to provide as much data as possible about the individuals who made up this prosopography.⁴⁴

Biographies, obituaries and the census were used as ancillary material because not every Harley Street practitioner will have been known well enough to have had a significant piece written about him; thus, these sources could not have been used exclusively. When information could not be found in the *Medical Directory*, such as the dates of birth and death, it was supplemented by other sources, for example, *Munk's Roll* or *Plarr's Lives for Fellows of the Royal Colleges of Physicians and Surgeons*. The

⁴³ See Charles Harvey and Jon Press, *Databases in Historical Research* (London, 1996).

⁴⁴ Harvey and Press, *Databases*, p. 11.

most reliable method of encapsulating the entire Harley Street medical population for the period was to work from the listings in the *Directory* and *Register*.

The Medical Profession and Advances in Medicine, 1845-1914

The early nineteenth century saw the arrival of hospital medicine or the “birth of the clinic” with hospitals becoming centres of medical knowledge and a bastion of medical power.⁴⁵ Microscopic anatomy, physiology, pathology and pharmacy provided the basis for innovations in medicine.⁴⁶ In mid-Victorian Britain, universities received very little support from the state for any kind of medical research. The nineteenth century saw the introduction of new technologies, many of which were used for physical examinations. The stethoscope was invented in 1816 whilst the mid-Victorian ophthalmoscope and the laryngoscope provided greater thoroughness.

When George Harley arrived in Harley Street in the 1850s, the microscope was then not used widely.⁴⁷ By 1870, however, the microscope “which began to revolutionise science in 1830” had become easier and cheaper to use and it subsequently became a standard instrument in medical science.⁴⁸ By the 1860s compact thermometers could be used to measure body temperatures and sphygmomanometers, discovered in 1835

⁴⁵ W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge, 1994), p. 25.

⁴⁶ Erwin Ackerknecht, *A Short History of Medicine*, (New York, 1982), p. 159.

⁴⁷ Tweedie, *Harley*, p. 316.

⁴⁸ Brian Bracegirdle, “The Microscopical Tradition” in W. F. Bynum and Roy Porter, eds., *Companion Encyclopedia of the History of Medicine*, (London, 1993), pp. 102-106.

but used more commonly in the 1890s, allowed for the testing of blood pressure.⁴⁹ Laboratory studies in physiology, experimental pathology and pharmacology led to increased clinical and diagnostic knowledge and nineteenth century practitioners of organic chemistry, microscopy, physiology and other science related disciplines were a part of a new endeavour involving laboratory-based medicine.

Before the introduction of anaesthetics such as ether in the 1840s and later chloroform, which was discovered in 1831 and became popular following its use by Queen Victoria during the birth of Prince Leopold in 1853, invasive surgery was limited to those operations that were small and regarded as safe in scope; thus, it was not possible to undertake lengthy surgical procedures, especially those that required considerable precision. Though the use of effective anaesthesia made unbearably traumatic internal procedures feasible, it did not completely revolutionise surgery because of the abysmal post-operative death rate of invasive surgery: postoperative infection was, in general, unavoidable. Joseph Lister (1827-1912) first developed effective antisepsis (to significantly reduce the infective agents in the wound) and asepsis (prevention of infection in the wound) techniques. By 1890, aseptic surgery had established itself and coupled with the use of surgical masks, gloves and gowns, infection was radically reduced and post-operative death rates plummeted.⁵⁰

⁴⁹ Roy Porter, *Blood and Guts*, (London, 2002), p. 84.

⁵⁰ For a discussion of the sepsis and the debate on Lister's methods of its prevention, see Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present*, (London, 1999), pp. 360-374.

At the beginning of the nineteenth century, a unified medical profession did not exist; practitioners of medicine could be divided into three distinct 'estates' of physicians, surgeons and apothecaries. This tripartite division of the medical profession was merely a formal construct, as the boundaries were vague in practice. At the top of the hierarchy were the pure physicians who were usually university educated in the liberal arts such as the classics. They were relatively few in number, but they wielded considerable power in everyday medical affairs.⁵¹ Physicians were concerned with the 'internal' treatment of the body; diagnosis and prescription, but not the provision of drugs. The surgeon dealt with the external care such as repairing fractures and suturation of wounds. The fluidity of practice was evidenced by the treatment of diseases of the skin, which was initially the responsibility of the surgeon and by the end of the nineteenth century came within the sphere of the physician or dermatologist. In principle, apothecaries compounded and administered drugs; in practice, the majority visited patients and diagnosed their complaints. They were restricted to charging for the drugs dispensed and not for the visit so as not to encroach on the physicians' remit.

By the mid-1880s when a unified medical profession developed, following the 1858 Medical Act and conjoint examinations in medicine and surgery, medical practitioners had formed the modern bipartite structure of

⁵¹ Paul K. Underhill, 'Science, Professionalism and the Development of Medical Education in England: An Historical Sociology', (PhD, University of Edinburgh, 1987), p. 75.

élite consultant surgeons and physicians on the one hand and the main body of general practitioners on the other.

The Historiography of Harley Street

No known books have been printed on the subject since Reginald Pound wrote *Harley Street* in 1967.⁵² A small number of articles have been written and those by Zachary Cope and Gordon Wolstenholme are the most comprehensive.⁵³ Of the books that have been published, Cyril Phillips Bryan's *Roundabout Harley Street*, Harvey Graham's *A Doctor's London*, Pound's *Harley Street* and, in particular, Percy Flemming's *Harley Street From Early Times to the Present Day* provide useful background material on the building of Harley Street within the context of the Cavendish Estate.

⁵⁴ A more extensive account of the pre-Harley Street period can be found in publications on the history of Marylebone.⁵⁵ The existing scholarship on Harley Street lies in the genre of anecdotal accounts of the more colourful characters who were registered in the Street. Biographies and autobiographies of former medical residents of Harley Street provided useful additional material for qualitative analyses.⁵⁶ However, a reference to Harley Street in the title does not always indicate that it will be the central feature of the book and it can often be a misleading.

⁵² Pound, *Harley Street*, *passim*.

⁵³ Cope, 'Harley Street', *passim* and Wolstenholme, 'Harley Street Address', *passim*.

⁵⁴ Bryan, *Harley Street*, *passim*, Graham, *A Doctor's London*, *passim*, Flemming, *Harley Street from Early Times to the Present Day*, (London, 1939), *passim*.

⁵⁵ The definitive recent work on Marylebone is Gordon Mackenzie, *Marylebone: Great City North of Oxford Street*, (London, 1972). See also Thomas Smith, *A Topographical and Historical Account of the Parish of St. Marylebone*, (London, 1833) and Francis Henry Wollaston Sheppard, *Local Government in St. Marylebone 1633-1835*, (London, 1958).

⁵⁶ See for example William Byam, *Doctor Byam in Harley Street, an Autobiography*, (London, 1962), *passim*, Tweedie, *Harley*, *passim*, and R. Stevenson, *Morell Mackenzie*, (London, 1946), *passim*.

By the middle of the twentieth century, the image of Harley Street was well established in the minds of the public. Thus, biographies and autobiographies referring to the Street, impart an impression of the Harley Street doctor without describing what it was like to work in this area. For example, R. Scott Stevenson's, *Goodbye to Harley Street*, which is an autobiography of a Harley Street doctor from the 1920s and focused on the impact of the National Health Service had on medical practice, contains few references to Harley Street itself.⁵⁷ Likewise, *A Doctor's Diary by a Harley Street Doctor*, which may, indeed, have been written by a Harley Street doctor, does not include any references to the Street.⁵⁸ Written in the style of a medical self-help book, it contains the author's musings on topics such as one's health *vis-à-vis* the weather and the "misunderstandings" between the sexes. Meanwhile, *The Road to Harley Street* describes another author's training as a doctor and his later position in the army, provides only a couple of scant references to the Street, which appear in the last paragraph of the last page.⁵⁹ Despite its title, *The Harley Street Calendar*, was not about Harley Street, but was a collection of biographies on 11 eminent English speaking medical men spanning from the twelfth to the twentieth century.⁶⁰ This usage is interesting, as it indicates that Harley Street had by then become associated with eminent medical practitioners.

⁵⁷ R. Scott Stevenson, *Goodbye to Harley Street*, (London, 1954), *passim*.

⁵⁸ Anon, *A Doctor's Diary by a Harley Street Doctor*, (London, 1925), *passim*.

⁵⁹ William Byam, *The Road to Harley Street*, (London, 1963), p. 227.

⁶⁰ H. H. Bashford, *The Harley Street Calendar*, (Glasgow, 1929).

Critics of Harley Street

Since the nineteenth century, writers, playwrights, journalists and non-Harley Street medical practitioners have pilloried Harley Street consultants for their avarice.⁶¹ The condemnation made by non-Harley Street practitioners, remarked a journalist in the 1960s, was because

the worst thing about Harley Street, the heart of private medicine, is supposed to be its roguery ... In its favour, the place can claim to have hundreds of 'personal physicians,' concentrated within a few streets in a way that's unequalled in the world. The real indictment, made by doctors who are not in private practice, is subtler: Harley Street takes the time and energy of skillful doctors who are not interested in advancing medicine, merely in practicing it for as much money as they can get their hands on.⁶²

In his address to medical students at University College London in 1903, Ernest Starling characterised cynically the West-end consultant, epitomized by a Harley Street practitioner, as more interested in the appearance of success than the advancement of knowledge. He warned them not to succumb to the allure of a lucrative West-end practice:

under present conditions a man, when he obtains a position on a hospital staff, even if not before, engages his consulting rooms at a high rental in some fashionable quarter. He imagines it is more to his advantage to wait for the crumbs which fall from the great man's table than to spend his time in adding to our knowledge of medicine ... and ... maintaining the appearance of affluence which is supposed to be a necessary condition of success as a consultant ... He may now become a respected West-end consultant: he will never add anything to the science of medicine.⁶³

It will be shown in Chapters 4 to 6 that Starling's comments were unwarranted for the Harley Street cohort. Whilst Starling may have perceived the West end medical consultant to contribute little to the

⁶¹ H de Vere Stacpoole, *Harley Street, a Novel*, (London, 1946), p. 39, the author referred to Harley Street as a "money racket", a place where specialists "cling together" for mutual benefit. See also, Sydney Horler, *The Formula, A Novel of Harley Street*, (London, 1934), pp.15, 19, the consultant Mathieson Wynne determined as a student to practice in "fashionable" Harley Street, as he was "determined to make money".

⁶² Ferris, *Doctors*, p. 23.

⁶³ Ernest H. Starling 'Address to the Medical Students at University College London', *BMJ* Oct. 10, 1903, p. 912.

advancement of medicine, the analysis of the cohort's achievements in this thesis makes his assessment erroneous.

Although Charles Dickens (1812-1870) refers to Harley Street in *Little Dorrit* (1857) as a “distinguished address” and “that grand destination” inhabited by “Society” Dickens lamented upon the dreariness of the Street and described its layout as:

like unexceptionable Society, the opposing rows of houses in Harley Street were very grim with one another ... the expressionless uniform twenty houses, all to be knocked at and rung at in the same form, all approachable by the same dull steps, all fended off by the same pattern of railing, all with the same impracticable fire-escapes, the same inconvenient fixtures in their heads, and everything without exception to be taken at high valuation.⁶⁴

The stereotype of the avaricious Harley Street consultant was satirised, though not actually identified, in George Bernard Shaw's (1856-1950) play, *The Doctor's Dilemma* (1906), at a time when, as Michael Neve argued, “hostility to the medical profession [was] perhaps at its height”, though this later diminished because of the effectiveness of antibiotics and to a lesser extent the public-health movement.⁶⁵ In Shaw's play, the dilemma for the socially esteemed doctor Sir Colenso Ridgeon, recognised by many to have been based on Sir Almroth Wright (1861-1947), the eminent bacteriologist who had consulting rooms in the Harley Street Area, was whether he should save the life of the amoral Louis Dubedat, who was suffering from tuberculosis or let him die; thereby, making Jennifer

⁶⁴ Charles Dickens, *Little Dorrit*, Angus Easson (ed.), (first edition 1857-58, this edition London, 1999), pp. 243 and 251-252.

⁶⁵ Michael Neve, 'Medicine and Literature', in W.F. Bynum and R.S. Porter, (ed.), *Routledge Companion to the History of Medicine*, (London, 1993), p. 1533. George Bernard Shaw, *The Doctor's Dilemma*, (first edition 1911, this edition London, 1926). See also Martin Meisel, *Shaw and the Nineteenth Century Theatre*, (New York, 1984), pp. 233-242 and Harold Bloom, (ed.) *George Bernard Shaw*, (New York, 1987).

available for him. Dubedat was the husband of Jennifer with whom Ridgeon was infatuated. Shaw had a derisory view of medical ethics and he condemned the medical élite's avidness and arrogance. A. J. Cronin made similar observations about unscrupulous consultants in his popular novel *The Citadel* (1937), and he applauded the social conscience of the ordinary family doctor.⁶⁶

Harley Street medical practitioners were again criticised in Virginia Woolf's novel *Mrs Dalloway* (1925). Woolf found an outlet for her condemnation of the treatment she received for her depression by a number of consultants, including the "eminent Harley Street nerve specialist", George Savage (later Sir), Sir Maurice Craig and Theophilus Bukeley Hyslop.⁶⁷ The prevailing view amongst these physicians was that Woolf's intellectual pursuits, particularly the solitary nature of her learning, contributed to her depression. Savage denounced the effect of "useless book learning [on] the weaker sex", whilst Hyslop argued that Woolf's choice of modern literature was proof of her mental illness.⁶⁸ Craig, with the agreement of Woolf's husband Leonard, advised her against having children, a decision which Virginia deeply resented.⁶⁹

⁶⁶ A. J. Cronin, *The Citadel*, (London, first published in 1937, this edition 1984). See also Neve, 'Medicine and Literature', p. 1530.

⁶⁷ Virginia Woolf, *Mrs Dalloway*, (London, first published 1925, this edition 1996), see also Joanne Trautmann Banks, "Mrs Woolf in Harley Street", *Lancet*, Apr. 11, 1998, pp. 1124. Although George Savage, Sir Maurice Craig and Theophilus Bulkeley Hyslop were referred to as Harley Street doctors they did not work in the Street itself but in the Harley Street Area, only Henry Head had a practice in Harley Street.

⁶⁸ Banks, "Mrs Woolf", p. 1126.

⁶⁹ Woolf, *Dalloway*, p. 94. Also, see Nigel Nicolson and Joanne Trautmann, eds., *The Letters of Virginia Woolf*, (New York, 1975-82), Vol. 1, p. 190.

Leonard later called in Sir Henry Head, the famous Harley Street experimental neurologist, after Virginia's failed suicide attempt in 1913.⁷⁰ Head was described as enlightened, as one "whose ideas were so far in advance of others that he is still cited today" and "a man who entertained Freudian ideas seriously".⁷¹ However, his *avant-garde* approach did little to change Woolf's condemnation of the Harley Street specialist. In her novel *Mrs Dalloway*, the general practitioner Dr. Holmes and the nerve specialist Sir William Bradshaw were portrayed as vain, insensitive and grasping. Holmes suggested to Septimus Warren Smith, one of the novel's protagonists, that the antidote to his malaise was to take up a hobby. When this remedy failed to cure Septimus of his shell shock, Holmes said that if they had no confidence in him then Septimus and his wife Lucrezia should, "if they were rich people ... go to Harley Street."⁷² The Warren Smiths later called on Sir William Bradshaw whose ostentatious car was parked outside his house in Harley Street:

Sir William Bradshaw's motor car; low, powerful, grey with plain initials interlocked on the panel, as if the pomps of heraldry were incongruous, this man being the ghostly helper, the priest of science; and, as the motor car was grey, so, to match its sober suavity, grey furs, silver grey rugs were heaped in it, to keep her ladyship warm while she waited. For often Sir William would travel sixty miles or more down into the country to visit the rich, the afflicted, who could afford the very large fee which Sir William very properly charged for his advice.⁷³

Whilst her husband made house calls to his wealthy patients, Lady Bradshaw usually waited in the car and contemplated the "wall of gold,

⁷⁰ Anon, 'Henry Head', *BMJ*, Oct. 19, 1940, p. 539.

⁷¹ Banks, "Mrs Woolf", p. 1126.

⁷² Woolf, *Dalloway*, p. 94.

⁷³ *Ibid.*, pp. 94-95.

mounting minute by minute” as the consultation time ticked away.⁷⁴ Bradshaw’s solution to Septimus’s problem was rest, lots of rest; the very treatment that Woolf’s consultants had suggested to her and which she detested.⁷⁵

Not all fictional accounts of the Harley Street medical practitioner, however, sought to denounce his image or practices: novels and romantic fiction tended to exaggerate the merits of the eminent consultants.⁷⁶ Harley Street appears in the early nineteenth century literary genre as a popular London address for Society ladies who came to town.⁷⁷ In Jane Austen’s *Sense and Sensibility* (1811), a couple of the novel’s central characters, the Dashwoods, took a house in Harley Street for some of the winter months. There they later held a grand dinner with numerous servants in attendance and where “everything bespoke the mistress’s inclination for shew, and the master’s ability to support it.”⁷⁸ This house was later the scene for Mrs John Dashwood’s hysteria. Austen was familiar with the Street as her brother,

⁷⁴ *Ibid.*, p. 95.

⁷⁵ *Ibid.*, p. 151.

⁷⁶ For example, Anne Vinton, *Lady in Harley Street*, (London, 1965). See also, Philip Inman, *Straight runs Haley Street*, (London, 1942), p. 9, in which the author stated that “there is something magnetic about its [Harley Street] very name. To the lay mind, it suggests the best medical opinion that can be obtained... To the young medical student it represents the apotheosis of the profession”.

⁷⁷ Francis Henry Wollaston Sheppard, *Local Government in St. Marylebone 1633-1835*, (London, 1958) and R.W. Chapman, *The Novels of Jane Austen, the Text based on Collation of the Early Editions, Mansfield Park*, (first edition 1814, this edition Oxford, 1988). In this novel Maria Rushworth’s adultery and elopement with Henry Crawford took place in Wimpole Street, see p. 440.

⁷⁸ Jane Austen, *Sense and Sensibility*, (first edition, 1811, this edition London, 1994), p. 227.

Henry, married their cousin Eliza at St Marylebone Parish Church and the couple lived for a time in Harley Street.⁷⁹

Limitations of the Thesis

This thesis is not a study of the comparative affluence of the Harley Street group. Determining the wealth of the cohort would be problematic as dates of birth and death for the entire cohort were not available and access to family archives was limited. Moreover, these archives, where extant, are not stored in one location therefore regional archives would have had to be investigated. This was not practical given the size of the Harley Street population; moreover, the disparate nature of this source and the variation in the available material would have increased the difficulty of a prosopographical analysis. Barbara English outlined the difficulties in using family archives and probate records in analysing a person's wealth and argued that it was "not possible to find the net value of an estate from probate records before 1881, for no such figures were recorded."⁸⁰ Even after this period, the probate of a will only included goods and chattels but not land in the valuation.

An alternative source, the death duty registers filed at the PRO contain the net value of estate and a valuation of land from 1853. However, although they are a valuable source for the historian and genealogist, the registers are closed to inspection for a seventy-five year period and as a number of the cohort died after 1927, the registers could not be used in the

⁷⁹ Mary Cotton, 'Jane Austen in Marylebone?', *The St. Marylebone Society Newsletter*, Spring 1998, Number 292, p. 1.

⁸⁰ Barbara English, 'Probate Valuations and the Death Duty Registers', *Bulletin of the Institute of Historical Research*, Vol. LVII, 1984, pp. 82

prosopographical analysis.⁸¹ Moreover, they provide valuations of land and in some cases personal property, but do not give details of the annual income accrued by an individual; thus, it is not possible to establish the remuneration earned by the cohort. Since this thesis is a study of the medical practitioners in Harley Street, other residents or institutions in the Street do not form part of the analysis, although they are referred to in the narrative.

Before any statistical or qualitative analysis of the Street's medical practitioners is presented, it is essential to locate Harley Street geographically. By doing this, it is possible to deduce, in part, the rationale that a medical practitioner used in determining a suitable address from where he could practice. The geographical location, which places the development of Harley Street in the context of the urbanisation of the parish of St. Marylebone, is examined in the next chapter. The early eighteenth century history of the parish includes the projections by the Cavendish-Harley Estate for Cavendish Square and Harley Street.

⁸¹ English, 'Probate Valuations', pp. 86-91.

CHAPTER 2

The Birth of the Medical Elysium

The Topography of Harley Street

The emergence and development of enclaves with their own particular identity, such as the synonymous character of medical practitioners and Harley Street, tailors and Savile Row or journalists and Fleet Street, reflects a period in history and their development is relatively slow.¹ The medical quarter of London's Harley Street did not spring to life spontaneously; rather its growth was protracted. From its beginnings in 1729, another 150 years were to elapse before the rise in the numbers of medical practitioners registered in the Street could be considered significant. The building of Upper Harley Street did not begin until 1770, and it was not until 1866 that it was incorporated into Harley Street.² Upper Harley Street and Lower Harley Street were then renumbered with even numbers on the East Side and odd numbers on the West Side.³

The region that has been known as Harley Street Area since the early eighteenth century was part of St. Mary-le-bone whose etymology provides us with a clue to its geographical location. Mary-le-bone takes its name from

¹ Though tailoring was practised in West End of London in the 16th century, Savile Row did not acquire its reputation for tailoring until the late 1790s and it was not until the beginning of the 19th century that the area became identified with bespoke clothing. Although Fleet Street was home to the printing press from the 1500s, it was not until London's first daily newspaper, *Daily Courant* was published in 1702 and other newspapers were created from the 1720s that the Street became established as the newspaper district in the eyes of the public.

² Cyril Phillips Bryan, *Roundabout Harley Street: The Story of Some Famous Streets*, (London, 1932), p. 92.

³ Sir Zachary Cope, "Harley Street," *History of Medicine*, 4, 2, p. 8. Information for the renumbering comes from the archives of the Howard de Walden Estate.

the former village of Ty-borne or Ty-bourne. The Anglo-Saxon word for brook is 'bourne' and Ty-bourne was located on the east bank of a brook, which ran down from Hampstead to the Thames.⁴ A 1742 *Survey of London* described the village of Tyburn as falling into ruin in the fourteenth century, its church, dedicated to St. John the Evangelist, looted and stripped bare.⁵ The parishioners prevailed upon the Bishop of London to erect a replacement in a new location. He acceded to their petition, granting them a rebuilding licence in October 1400 to erect a new church. This church, built on the site of an old chapel dictated to the Blessed Virgin Mary, was renamed St. Mary at the Bourne. The nomenclature was partly due to its proximity to the Bourne and also to differentiate it from other churches dedicated to St. Mary in the nearby villages of Islington and Kensington.⁶ By 1453 records indicated that the Anglo-Saxon name Ty-bourne had begun to be replaced by Marylebone.⁷ The church and the surrounding area have been referred to variously as *Marybourne*, *Marybone*, *Mary-la-bone*, *St. Mary-la bonne*, *Maryburn*, *Maribone* and to echo Samuel Pepys, *Marrowbone*.⁸

Accounts of the two manor houses, Tyburn and Lileston to the east and west of Marylebone respectively, appear in the Domesday Book of 1086.

⁴ Thomas Smith, *A Topographical and Historical Account of the Parish of Saint Marylebone*, (London, 1833) and Francis Henry Wollaston Sheppard, *Saint Marylebone 1633-1835*, (London, 1958), p. 3.

⁵ Anon, *A New and Compleat Survey of London in Ten Parts*. Vol. II, (London, 1742), p. 1225.

⁶ Smith, *Topographical Account*, p. 3 and E. B., Ashford, *Tyburn Village and Stratford Place*, (London, 1969), pp. 6-7.

⁷ The Rev. H.J. Matthews, *Old Marylebone and Some of its Famous People*, (London, 1941), p. 5.

⁸ Anon, *Survey of London*, p. 1225 and quoted in, Anon, *St. Marylebone: A Sketch of its Historical Development*, (London, 1952), p. 5.

The Tyburn Manor encompassed the present Regent's Park, the Howard de Walden Estate and the Berners Estate. The Lilestone manor included the present Portman Estate, the Eyre Estate and Harrow School.⁹ The Tyburn manor is of interest in this thesis, as it was on the grounds of this manor that the development of Cavendish Square and the adjoining streets was to take place in the early eighteenth century. Aubrey de Vere, second Earl of Oxford, who had been responsible for the building of Marylebone's first church, had acquired both manors in the thirteenth century.¹⁰ The manors changed hands during the course of the fourteenth and fifteenth centuries. In 1544, Henry VIII procured the Tyburn Manor and the surrounding area from Thomas Hobson, in exchange for some church lands, so that he might indulge his passion of hunting to hounds.¹¹ In 1583 Elizabeth I granted Edward Forset a 21 years' lease of the Tyburn Manor. King James later sold the Manor to Edward Forset in 1611, not including the park, for 829l.3s.4d. It remained in the Forset family until it passed to Edward's great-grandson, John Austen, who in 1710 sold it to John Holles, Duke of Newcastle.¹² A plan of the Marylebone Estate is reproduced in Plate 2.1.¹³

⁹ Anon, *Survey of London*, p. 4.

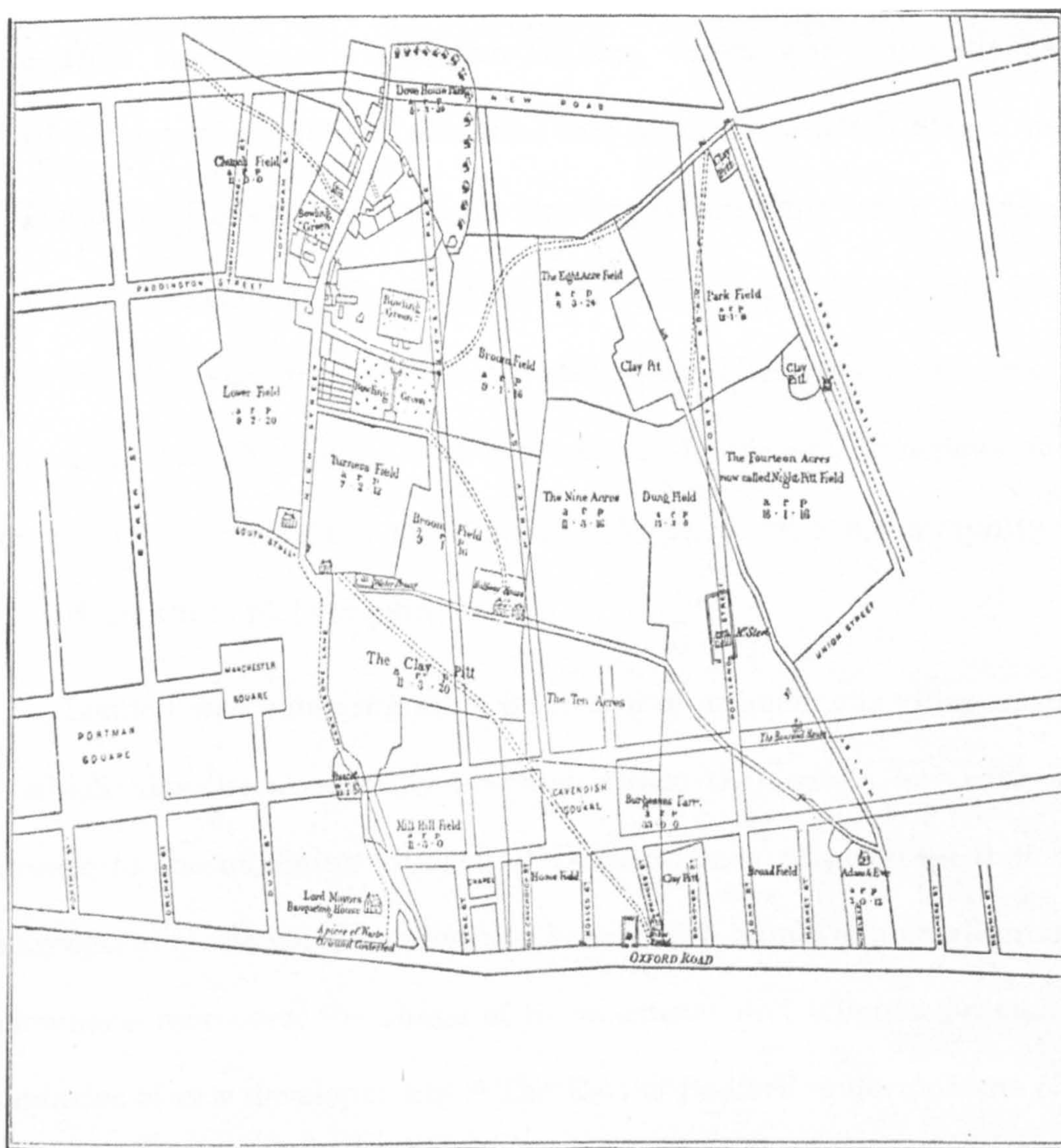
¹⁰ Gordon Mackenzie, *Marylebone: Great City North of Oxford Street*, (London, 1972), p. 20.

¹¹ *Ibid.*

¹² Smith, *A Topographical Account*, p. 9. Holles paid £17,500 for the land, which had a rental income of about £900 per year, see Harvey Graham, *A Doctor's London*, (London, 1952), p. 16.

¹³ Henry Pratt, *Plan of the Marylebone Estate when purchased by the Duke of Newcastle, 1708*, British Library, the Crace Collection, port. XVI.18.

Plate 2.1, Plan of the Marylebone Estate



PLAN OF THE MARYLEBONE ESTATE
When purchased by the Duke of Newcastle, 1708,

This plan made in 1708, just prior to the Duke of Newcastle's purchase of the land shows the village of Marylebone before development. Fields then surrounded Cavendish Square, which was originally called Oxford Square. Marylebone Lane runs into Marylebone High Street and to the East of the High Street stood the Bowling Green. This would later be the site of the Marylebone pleasure gardens.¹⁴ The map shows that Harley Street ran in a straight line, by the side of the Half-Way House Inn and between Cavendish Square and New Road. It traversed various fields: 'Brown fields', 'Broom field' and 'The Ten Acres.' A village community was still working these plots of land.

London was emerging as "a collection of autonomous villages, many [of] which have been carefully planned within themselves but with little reference to the adjoining villages."¹⁵ Donald Olsen emphasised that with the exception of the City, London had been in the hands of a small group of landowners; moreover, the shape of these estates and villages dictated the boundaries of new developments.¹⁶ The Earl of Bedford undertook one of the earliest of the large-scale developments when, in 1630, he laid out Covent Garden and the connecting streets. Following this, the construction of new residential areas of London moved gradually westward.¹⁷ In the 1650s, the Earl of Southampton built a vast London abode with Southampton Square (later Bloomsbury) at its frontispiece. A decade later, he granted building

¹⁴ Anon, *St. Marylebone*, p. 6.

¹⁵ Donald J. Olsen, *Town Planning in London*, (London, 1982), p. 5.

¹⁶ For further details, see James Anderson, 'Marylebone Park and the New Street, A Study of the Development of Regent's Park and the Building of Regent Street, London, in the first Quarter of the Nineteenth Century', PhD, (London, 1998), pp. 181-183.

¹⁷ Anderson, 'Marylebone Park', p. 7.

leases on his lands around the Square, with the proviso that the developers were to erect good quality brick housing.¹⁸ During the course of the 1660s, Henry Jermyn, the Earl of St. Albans, offered leases on sections of the 45-acre plot he held near St James's Palace. Speculative developers, well aware of the increasing demand by the courtiers and the aristocracy for suitable accommodation, were eager to take up the offer. Thus, St James's Square, St James's Street, the Haymarket, Jermyn Street and Pall Mall all came into being towards the end of the seventeenth century.¹⁹

The expansion of the West End during this time was the result of a number of factors. The decline of the City as a residential district was becoming apparent in the 1660s, following "the most violent plague London had ever known".²⁰ The death toll reached 100,000 and no sooner had the inhabitants recovered than the City was engulfed in flames. The great fire raged from Saturday the Second of September 1666 to the following Thursday, causing almost £11,000,000 worth of damage.²¹ Those who could afford it, moved out to the West End because, according to Roy Porter, "the West End was the finest place to live – a place to spend money, to entertain or just bask in being."²² By the 1750s, Sir Walter Besant noted that noblemen no longer lived within the City's boundaries; consequently, estates in the West End expanded.²³ Due to economies of scale, the conversion of

¹⁸ Stephen Inwood, *A History of London*, (London, 1998), p. 253.

¹⁹ Inwood, *London*, p. 254.

²⁰ John William Abbott, *A History of London, from the Earliest Period to the Present*, (London, 1821), p. 160.

²¹ Abbott, *A History of London*, pp. 163-166.

²² Roy Porter, *London, a Social History*, (London, 1996), p. 93.

²³ Sir Walter Besant, *London*, (London, 1892), p. 353.

these estates into groups of town houses was financially viable. The Duke of Westminster's estates encompassed the vast area of Mayfair, the present-day Belgravia and Pimlico. The Marquis of Northampton held the expanse of Islington and Clerkenwell, whereas the Earl of Oxford owned Cavendish Square and the area around it.²⁴ Landowners were keen to reap the financial rewards of leasing the lands while maintaining a reversionary interest in them. In *A History of London*, Stephen Inwood indicated that investment in the West End of London was easier to obtain than elsewhere.²⁵ In addition, this area was close enough to Westminster and St James's Palace to attract the nobility.

A spate of urbanisation occurred early in the eighteenth century, which gave rise to the designing of Cavendish, Hanover and Grosvenor Squares. Cavendish Square lay to the North of the Tyborne Road (later Oxford Street): the name of this Square vacillated between Oxford Square and Cavendish Square until the 1730s. According to Cyril Phillips Bryan, by 1734 it was referred to exclusively as Cavendish Square.²⁶ The *Survey of London* describes the "many streets of fine houses being lately erected in this neighbourhood", but also points out the name "Tyborne is still preserv'd in that of the gallows in this neighbourhood."²⁷ This association with the gallows and the fact that in contrast to Mayfair, Cavendish Square

²⁴ Olsen, *Town Planning*, p. 8.

²⁵ Inwood, *A History of London*, p. 258.

²⁶ Bryan, *Harley Street*, p. 59.

²⁷ Anon, *Survey of London*, p. 1226.

was relatively remote from the Court and Westminster, meant it was not as attractive to the fashionable set, as the other areas had proved to be.²⁸

In the early eighteenth century, Edward Harley decided to increase the prestige of his own holdings. He had been spurred on by the pecuniary benefits that his noble neighbours accrued through the conversion of their estates into upmarket dwellings.²⁹ In 1715, a plan was first mooted to provide residential accommodation in Cavendish Square and the streets that emanated from it.³⁰ The Duke of Newcastle, John Holles, an extremely wealthy man, had bequeathed the Manor and a “fortune of £500,000” to his daughter, Henrietta and his son in-law, Edward Harley.³¹ Harley later became the second Earl of Oxford and Mortimer, and Baron Wigmore of Wigmore in Hertfordshire.³² Henrietta had also inherited the vast estates of Welbeck in Nottinghamshire and Wimpole in Cambridgeshire from her father. She took the title Countess of Oxford following her marriage to Harley in 1713. Shortly after the death of the Duke’s widow in 1715, the Harleys commissioned a survey of the Cavendish Square area.³³ The task of surveying the square and its environs was given to John Prince. It was Harley’s intention to build elegant residential homes that would appeal to the tastes of the aristocracy and the upper classes.³⁴ He appointed the architect James Gibbs, who had worked for his father on the Harley estate,

²⁸ Inwood, *History of London*, p. 260.

²⁹ Anon, *St. Marylebone*, p. 6.

³⁰ Smith, *Topographical Account*, p. 154.

³¹ Alison Plowden, *Lords of the Land*. (London, 1984), p. 147.

³² Sir Zachary Cope, ‘Harley Street’, *History of Medicine*, 4, 2, p. 4.

³³ Mackenzie, *Marylebone*, p. 21.

³⁴ *Ibid.*, p. 23.

Wimpole Hall in Cambridgeshire and was acknowledged to be “the most considerable master of architecture since Wren” to supervise the building.³⁵

These new town houses were to be fashioned in the English Palladian style. It was the antithesis of seventeenth century Baroque grandeur and that was the key to its popularity.³⁶ For estate owners such as the Earls of Shaftesbury and Burlington, and later the second Earl of Oxford, the Baroque style had lost its appeal. Sir Christopher Wren, Baroque’s greatest English exponent, had dominated architecture in England for nearly 70 years, from the death of Inigo Jones in 1652 to the 1720s.³⁷ Following Burlington’s visit to Italy as part of his Grand Tour, he commissioned the remodelling of his London home in 1719 in the style of Palladio and Inigo Jones.³⁸ Around this time, the second Earl of Oxford had decided that the English Palladian style was in keeping with the type of classical architecture befitting his town houses for the upper classes.

A report in *The Weekly Medley* of 13 September 1718, made a comparison between Hanover Square and Cavendish Square. The latter, it declared

seems a higher and finer situation, is marked out a very spacious and Noble Square, and many streets that are to form avenues to it. This square, we hear, is to be called Oxford-Square, and that ground has been taken to build houses in it by the Right Honourable Lords, the Earl of Oxford, the Earl of Carnarvon, the Lord Harcourt, the Lord Harley, and several other Noble Peers of Great Britain. The ground sold at first for 2s.6d. per foot, afterwards for 15s.³⁹

³⁵ *DNB*, Vol. VIII, p. 1147 and John Summerson, *Georgian London* (London, 1945), p. 90.

³⁶ Summerson, *Georgian London*, p. 24.

³⁷ Stephen Parissien, *Palladian Style*, (London, 1994), p. 57.

³⁸ Parissien, *Palladian*, p. 63.

³⁹ Quoted in Smith, *Topographical Account*, p. 157.

The increase in price demonstrated the Square's increasing popularity. In fact, work began on the Square in 1717 and the first house was built in 1720. Edward Harley was a zealous collector of books, manuscripts, paintings and memorabilia. It was said that his "habitual indolence, rather than incapacity prevented him from taking part in public affairs; nor did he care for general society", preferring the company of those who were connected to the Arts.⁴⁰ Despite the pleasure he derived from the planning aspects of building and landscaping, he was not interested in their execution. Consequently, he delegated the supervision of the project to his uncle, also called Edward Harley.

A copy of a plan dated 1719 and based on John Prince's survey of the Cavendish Estate is duplicated in Plate 2.2.⁴¹ Prince's survey indicates a grid system of streets around the Square with Harley Street to the northeast. The plan also provides for Oxford market and a chapel, called Oxford Chapel until 1732, which later became a church dedicated to St. Peter at Vere Street.⁴² The distance to Westminster from various areas such as Bloomsbury or the City is included with the plan. This timetable (Plate 2.3) shows that the proximity of Marylebone to Westminster is relatively closer than the other areas.⁴³ The timetable is thought to display the desirability of Marylebone as a residential district.⁴⁴

⁴⁰ 'Edward Harley, (1689-1741), *DNB*, Vol. 8, 1908, pp. 1278-1280.

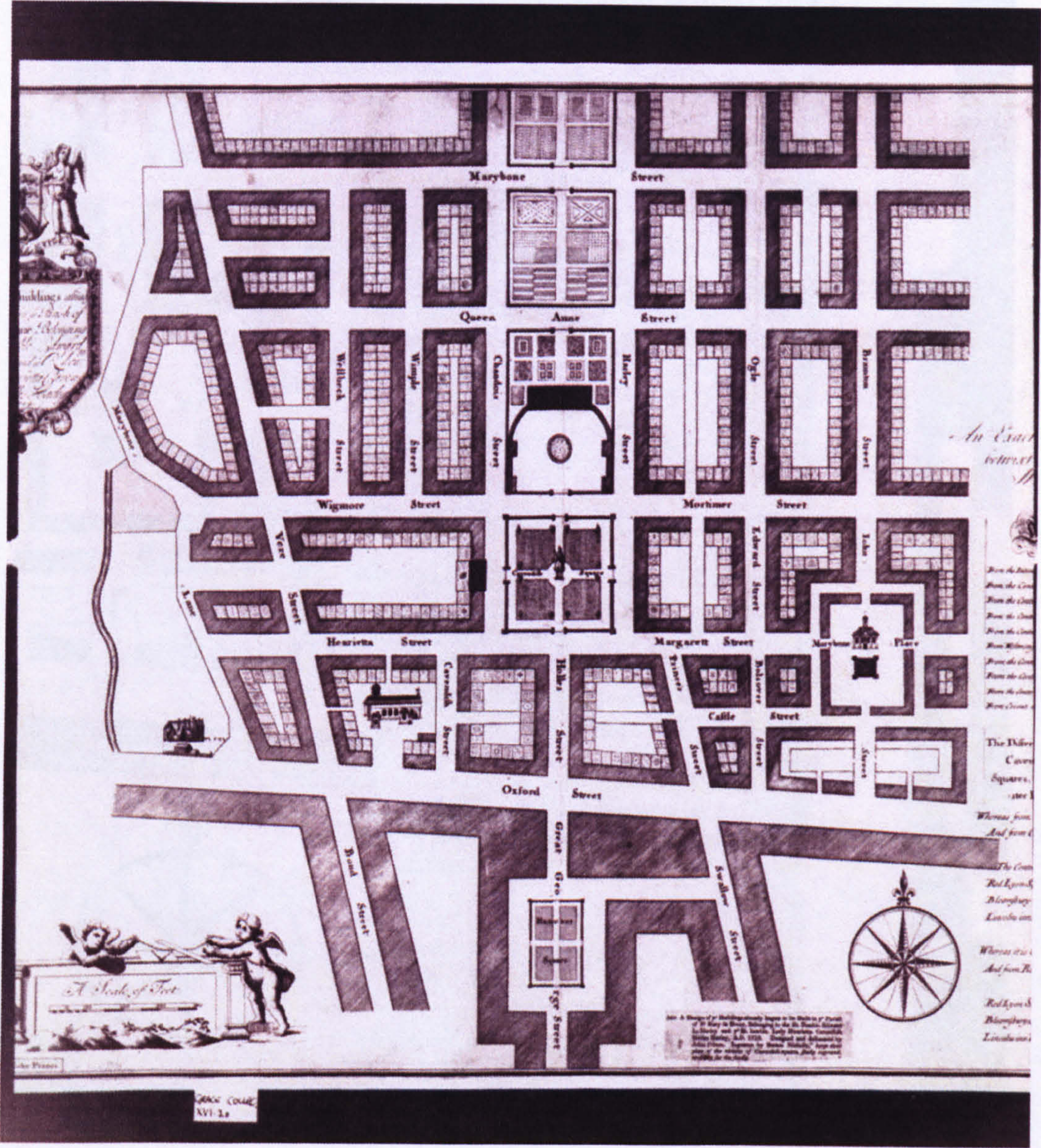
⁴¹ 'Map of Marylebone' by John Prince in 1719, the British Library, Maps Crace, port. XIV. 20.

⁴² Mackenzie, *Marylebone*, p. 40.

⁴³ Timetable on a 'Map of Marylebone' by John Prince in 1719, the British Library, Maps Crace, port. XIV. 20.

⁴⁴ Summerson, *Georgian London*, p. 90.

Plate 2.2, 'Map of Marylebone' by John Prince in 1719



Edward Harley's father Plate 2.3, Timetable 1719 station, including the Earl of Carnarvon (who later became the Duke of Chandos), the Lords

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Government sought to reduce the debt by introducing a Land tax and obtaining loans from private investors. The South Sea Company was

There were certainly a number of prospective buyers who saw its appeal:

amongst those who acquired plots of land were men who had served with

⁴ Smith, *Topographical Account*, pp. 103-105, and Mackenzie, *Maryland*, p. 44.

⁵ Mackenzie, *Maryland*, p. 44.

Edward Harley's father Robert, in the Tory administration, including the Earl of Carnarvon (who later became the Duke of Chandos), the Lords Dartmouth and Bathurst, and the Lord Chancellors Harcourt and Bingley.⁴⁵ Carnarvon, who had amassed a huge fortune as Paymaster General to Queen Anne, took a large plot on the north side of the square. There were only a couple of other houses there in 1720. To the east of the Square, stood Harcourt House built by Lord Harcourt, the ex-Tory Lord Chancellor. Lord Bingley, an ex-Chancellor of the Exchequer, commissioned Bingley House, which was situated on the west side of the Square.⁴⁶ When Bingley House came on the market in 1773, Harcourt's grandson purchased it and the name was then changed to Harcourt House.⁴⁷

The South Sea Company

The augmentation of Cavendish Square stalled later in the 1720s, partly due to the lack of investment following the failure of the South Sea scheme. Robert Harley, first Earl of Oxford and Mortimer, was instrumental in setting up a new joint-stock company. He was Chancellor of the Exchequer and later Lord Treasurer in Queen Anne's reign (1702-1714). Harley's Tory government came to power in 1710. At the time, the debts being incurred by the Spanish War of Succession (1702-1713) were mounting. The Government sought to reduce the debt by introducing a Land tax and obtaining loans from private investors. The South Sea Company was

⁴⁵ Anderson, 'Marylebone Park', p. 188.

⁴⁶ Smith, *Topographical Account*, pp. 155-156, and Mackenzie, *Marylebone*, p. 44.

⁴⁷ Mackenzie, *Marylebone*, p. 44.

established as a means of raising capital to discharge the national debt.⁴⁸ The scheme proved successful initially and a total of £9,177,967, principally made up of Army debentures and Navy bills, was subscribed.⁴⁹ In January 1720, a few of the company's directors proposed that they would take over the whole of the National Debt.⁵⁰ The public, expecting fantastic returns on their investments bid the stock price up from £130 per share in June 1720 to £1,000 per share by December.⁵¹ Due to the over-inflated share price, investors began to get nervous. Panic ensued and on 8 December, the stock price fell from £1,000 to £150 and the company collapsed.⁵²

The Duke of Chandos' shares were worth £300,000 at their height but following the crash, were worthless.⁵³ The Duke had completed two of the wings of his mansion before the South-Sea disaster decimated his wealth and his project thus never reached fruition. It was said that the Duke died of a broken heart; Chandos's grief was no doubt exacerbated by the death of his infant son and heir during his christening.⁵⁴ It was left to the 3rd Duke of Chandos to build Chandos House between 1769 and 1770. Less ostentatious than the original projections made by the first Duke, it was nevertheless beautifully executed by the Adams brothers using the decorative

⁴⁸ The Company took on £9,000,000 of the National Debt. See Sir George Clark, *The Later Stuarts*, (Oxford, first edition 1934, this edition 1965), pp. 249–250.

⁴⁹ John Miller, *An Interesting Account of the South Sea Scheme, 1720*, (London, no date but probably late 18th century), pp. 295–296 and Bruce G. Carruthers, *City of Capital*, (London, 1999), p. 154.

⁵⁰ Miller, *South Sea Scheme*, pp. 298–299.

⁵¹ John Cannon, ed. *The Oxford Companion to British History*, (Oxford, 1997), pp. 879–880.

⁵² Miller, *South Sea Scheme*, p. 13.

⁵³ Lee, Christopher., *This Sceptred Isle, 55 BC to 1901*, (London, 1997), p. 323 and Mackenzie, *Marylebone*, p. 156.

⁵⁴ Anon, *The Builder*, May 10, 1873, p. 363.

plasterwork, which was to become their trademark. This building at 11 Chandos Street now houses the Medical Society of London.⁵⁵

The disaster of the South Sea Company venture was not the only reason for estate owners to pause. The aftermath of the Nine Years War (1688 – 1697) and the Spanish War of Succession (1702 – 1713) had pushed up interest rates making the return for speculative building appear less attractive.⁵⁶ Apart from this, house building in eighteenth century London did not surge ahead unabated. The elasticity of supply for housing was not simply linked to demand: Summerson maintained that construction came in waves, for political, psychological and economic reasons.⁵⁷ Olsen pointed out that periods of slow population growth did not necessarily result in a low level of demand for new housing. He further maintained that, “great building booms sometimes accompanied a period of relative stability in population.”⁵⁸ In the absence of the need for urbanisation in eighteenth century London, a significant motive in encouraging estate owners to lease their land may simply have been the twin desires of prestige and profit.

The hiatus was, however, brief and by 1740, sites had developed both sides of the Tyburn. The first of these appears to be Hanover Square and George Street, which by 1717 housed a number of military Whig generals.⁵⁹ Following this, the Earl of Burlington’s Savile Row and Burlington Street

⁵⁵ Porter, *London*, p. 110 and Walter Rivington, *The Medical Profession of the United Kingdom*, (London, 1887), p. 452.

⁵⁶ Inwood, *History of London*, p. 258.

⁵⁷ Summerson, *Georgian London*, p. 81.

⁵⁸ Olsen, *Town Planning*, p. 14.

⁵⁹ Summerson, *Georgian London*, p. 82. Summerson lists the Generals Evans, Carpenter and Pepper and Lord Cadogan, all of whom served in Marlborough’s military campaigns.

were planned in the 1720s.⁶⁰ During the 1730s and 1740s, the Duke of Devonshire had established Berkeley Square. The population of London had remained constant during this time, increasing by just under 0.3%, from approximately 674,000 in 1700 to approximately 676,000 in 1750.⁶¹

To rekindle interest and as an incentive to the investors, Edward Harley commissioned the building of the chapel at Vere Street together with the Oxford Square market in the 1720s. By 1724 the chapel designed by Gibbs had been completed.⁶² Two years later, 34 houses had been built around Cavendish Square, though just over a third were unoccupied.⁶³ Charles Bridgman had already landscaped the square itself.⁶⁴ London was, at the time, a dangerous place to live and Marylebone was not exempt from crime and mob unrest.⁶⁵ The vestry proceedings at Marylebone indicated that a night watchman was employed to guard the streets, whilst the Earl permitted the use of the manorial court building as a watch-house. Those arrested were kept here until they appeared before the Justices of the Peace.⁶⁶ Parish officials in Marylebone were not, however, unique in taking measures to reduce the rate of crime, and coupled with the improvements

⁶⁰ *Ibid.*, p. 83.

⁶¹ Mabel Craven Buer, *Health, Wealth, and Population*, (London, 1926), p. 272. The first census of the British population was carried out in 1801. The demographic figures up to this point are estimates, principally based on parish records. See Robert Woods, *The Population History of Britain in the Nineteenth Century*, (Cambridge, 1992), pp. 9-10. E. A. Wrigley in Stephen Inwood's *A History of London*, (18), p. 270, estimates the population of London in 1700 as 575,000 and in 1750 as 675,000. This would amount to an increase of approximately 0.148%. I have taken Buer's figures as the extreme case, which nevertheless amounts to a relatively slow expansion.

⁶² Smith, *Topographical Account*, pp. 158-159.

⁶³ Bryan, *Roundabout Harley Street*, (26), p. 62.

⁶⁴ Summerson, *Georgian London*, p. 90.

⁶⁵ Sheppard, *Saint Marylebone*, pp. 23-26.

⁶⁶ *Ibid.*

mentioned above, the parish became a more attractive place in which to reside.⁶⁷

The Development of the Harley Street Area

Following established tradition amongst the aristocratic landowners, many of the streets that were in the process of being constructed around Cavendish Square in the early eighteenth century took the Harley family names. These were from the Earl and his wife's relations, titles and Estates.⁶⁸ Hence, Harley Street was named after the family; Henrietta Street named after Edward Harley's wife; Margaret Street was a tribute to Lady Margaret, his daughter and heir; Holles Street after John Holles, Harley's father-in-law, and Vere Street after the Veres, Earls of Oxford.⁶⁹ Mortimer Street, Wigmore Street and Wimpole Street are all references to the Harley country estates. Prince's Street was so named in honour of Harley's surveyor John Prince. Cavendish Street derives its name from Henrietta Cavendish Holles' (the Countess of Oxford) family. Mansfield Street's appellation comes from the Duke of Mansfield, Margaret Cavendish's uncle.⁷⁰

In 1741, Edward Harley died and the estate passed to his daughter, Lady Margaret Cavendish Harley and her husband the second Duke of Portland. The Cavendish Estate thereby passed into the Portland family and from them originate the names of Bentinck, Duke and Duchess Streets.

⁶⁷ Westminster, for example, had a well established system of street protection. By 1799 according to Sheppard, *Saint Marylebone*, p. 24, there were 155 night watchmen patrolling the area.

⁶⁸ Smith, *Topographical Account*, pp. 159-160.

⁶⁹ *Ibid.*

⁷⁰ Cope, 'Harley Street', p. 4.

Bulstrode Street is a reference to the Duke of Portland's family seat.⁷¹ The second Duke of Portland and his wife persevered and enhanced the Estate begun by Edward Harley.⁷²

A map by the surveyor, John Rocque (part of the map is in Plate 2.4), of the Marylebone district around Cavendish Square, dated 1747, depicts a configuration of streets, principally to the south and east of Cavendish Square.⁷³ This quarter was evidently well formed up to Mortimer Street with the named streets running parallel and perpendicular to Cavendish Square. To the north, the roads that were etched on the map appear nameless: they lead to a rural topography of fields, criss-crossed by village lanes. To the north-west, the Marylebone Gardens that were to halt the march of Harley Street, were reaching the zenith of their popularity. Unfortunately, visitors to the pleasure gardens had to be chaperoned by armed guards whilst making their way through the fields, for fear of being ambushed by robbers and highwaymen.⁷⁴

⁷¹Anon, *The Builder*, p. 363.

⁷²Ann Saunders, *Regent's Park, A Study of the Development of the Area from 1086 to the Present Day*, (London, first published 1969, this edition 1981), p. 47

⁷³John Rocque, with introductory notes by Ralph Hyde, *The A to Z of Georgian London: A Plan of the Cities of London and Westminster, and Borough of Southward, with Contiguous Buildings*, (London, 1747).

⁷⁴Mollie Sands, *The Eighteenth-Century Pleasure Gardens of Marylebone*, (London, 1987), p. 4.

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The Cavendish-Harley development was, however, not an immediate success, as the demand for houses for the nobility and gentry could not be sustained. The consequences of the war of the Austrian Succession (1743-1748) resulted in another slump in the building trade. There was a slight, but temporary shortage of up-market housing in the 1750s, but building was not resumed with any vigour until after the Peace of Paris in 1763.⁷⁵ Nevertheless, construction did not come to an abrupt halt, and the Cavendish-Harley development inched its way slowly towards Marylebone Gardens. The New Road or the Marylebone/Euston Road was under construction in 1757. It was built to relieve the traffic on Oxford Street and to provide a route to the cattle markets at Smithfield.⁷⁶

The houses in Harley Street and Wimpole Street were erected between 1740 and 1750. Dodsley, writing in the 1760s, refers to Harley Street's early incumbents as being present in 1752.⁷⁷ Upper Harley Street came under construction with the closing of the Marylebone Gardens. The gardens went out with a fizzle rather than a bang. After a number of postponements, they were finally closed to the public in 1778. The extravagant firework displays of the pyrotechnist, Giovanni Battista Torr  (d. 1780) and later his assistants were deemed a risk to the public.⁷⁸ By 1820, Upper Harley Street was firmly established on the map.

⁷⁵ Summerson, *Georgian London*, pp. 93-94 and 146. Peace followed the cessation of The Seven Years War (1756-1763).

⁷⁶ Anon, *St. Marylebone*, p. 7.

⁷⁷ Quoted in Cope, 'Harley Street', p. 4.

⁷⁸ Torr  retired in 1774, see Sands, *The Eighteenth-Century Pleasure Gardens*, pp. 111-123.

The first residents in Harley Street were not medical practitioners. Due to the area's proximity to Westminster, Cavendish Square and Harley Street proved to be popular with members of Parliament. Cope maintained that there were at least 20 MPs living at the Cavendish Square end in 1771. Whilst Wilkes found that by 1793, there were 16 MPs in Cavendish Square, Harley Street and Wimpole Street. The area was also heavily laced with members of the aristocracy and families of distinction.⁷⁹ It contained members of the upper echelons of the clergy, (bishops and archdeacons), the Admiralty and the armed forces, (colonels and generals) as well as foreign diplomats. The Iron Duke, Wellington lived at number 11 Harley Street (1806-1807). The arrival of the medical men into these areas of Marylebone is discussed in the next section.

The Birth of Harley Street as a Medical Quarter

Harley Street became an increasingly fashionable area in which to live beginning in the 1770s.⁸⁰ Until the middle of the nineteenth century, however, medical practitioners were still underrepresented amongst the Street's genteel residents. As was mentioned in Chapter 1, various commentators have misrepresented the number of medical practitioners and the presence of the *first* doctors and surgeons in Harley Street. Zachary Cope claimed that following the physician William Rowley's departure there

⁷⁹ John Wilkes, *Directory of the Nobility, Gentry and Families of Distinction in London, Westminster & C.*, (London, 1793).

⁸⁰ Gordon Mackenzie, *Marylebone: Great City North of Oxford Street*, (London, 1972), p. 99.

was only one medical practitioner in Harley Street until 1809.⁸¹ The trade directories reveal, however, that the surgeon Benjamin Humpage was registered at number 66 Harley Street in 1791, and by 1802 the surgeons, Michael Bowman and John Lewis were at 9 Harley Street and 15 Upper Harley Street respectively.⁸²

Whilst Cyril Phillips Bryan and Harvey Graham maintained that the first medical practitioner to establish a practice in Harley Street was, indeed, William Rowley, they erroneously claimed that he remained the only medical practitioner there until John Latham moved to Harley Street about 1800.⁸³ William Rowley, a legendary self-publicist, appeared in a newspaper article in the late 1780s, in which he was lauded “an eminent physician” who cured a “gentleman of considerable fortune in Harley-street, Cavendish Square”. Dorothy and Roy Porter surmised that Rowley or his friends undoubtedly drew up the article.⁸⁴

Whilst it is possible that there were more medical men practising in Harley Street before 1800, this is difficult to ascertain since *The London Medical Directory* was not published until 1845.⁸⁵ Although registration in the *Directory* was voluntary, it provided, nevertheless, a particularly

⁸¹ Cope, ‘Harley Street’, p. 8, he contends that for the first fifty years of its existence Harley Street only housed one medical practitioner; William Rowley and that following him the first doctor “of repute;” John Latham, did not practice in Harley Street until 1809.

⁸² Wilkes, *Directory of the Nobility, passim* and *Holden’s Directory 1799* quoted in David Wright, *An Index of London Surgical Practitioners, 1736-1811*, (London, 1989), Vol. 1, p. 59 and *Holden’s Directory 1802*, quoted in Wright Vol. II, p. 313.

⁸³ Bryan, *Roundabout Harley Street*, pp. 119-120 and Harvey Graham, *A Doctor’s London*, (London, 1952), p. 25.

⁸⁴ Dorothy Porter and Roy Porter, *Patients’ Progress, Doctors and Doctoring in Eighteenth-Century England*, (Oxford, 1989), p.129.

⁸⁵ *Medical Directory*, 1845.

comprehensive list of qualified medical practitioners.⁸⁶ Unlike the *Directory*, registration in *The Medical Register* was compulsory for those holding a university medical degree or a licence from one of the recognised licencing bodies in the United Kingdom or Ireland.⁸⁷ This register, however, belongs to the middle of the nineteenth century with the first one dating from 1859.

A short-lived publication entitled the *Medical Register*, appeared in 1779, 1780 and 1783 only — though registration was not compulsory.⁸⁸ The 1783 *Register* included 152 Physicians residing in London and 820 members of the Corporation of Surgeons, both inside and outside London.⁸⁹ In the same year, the Apothecaries Society's list of members amounted to 346; the majority were based in London.⁹⁰ With the inclusion of the "Medical Establishment to the Royal Family", the total of all medical practitioners who were members of these licensing bodies, according to the 1783 *Medical Register*, was 1,351. An additional 337 physicians outside London had little to do with the London College of Physicians, as they generally held Scottish

⁸⁶ *Ibid.*, A comparative study between *The Medical Directory* and *The Medical Register* demonstrated that of the medical practitioners registered in Harley Street between 1859 (from the first edition of *The Register*) and 1914 only 2.38% appeared in the *Directory* but not in the *Register*. The results of this sample suggest that the *Directory* could therefore be viewed as approx. 0.97 % accurate.

⁸⁷ *Ibid.*, *The Medical Register*, years 1859 to 1914 and Rivington, *Medical Profession*, pp. 94 and 189.

⁸⁸ *The Medical Register*, (London, 1779, 1780 and 1783). The only medical practitioners registered in Harley Street in these publications were Mr. Boys, an Apothecary and William Rowley, a physician.

⁸⁹ *The Medical Register*, vol., 1783, pp. 10-14, this calculation excludes the Physicians to the Royal family and household, 135 are listed as resident in London plus 17 from 'Alterations and Additions' in the Appendix. The number of surgeons is made up of 753 'Members' listed, less 15 under omits in the Appendix, plus 82 additional members in Appendix, pp. 217-220.

⁹⁰ This is made up of 329 from the list of 'Members' and 'Apothecaries & c not included in the forgoing list,' pp. 26-30, plus additions from the Appendix p. 220.

or foreign degrees.⁹¹ These numbers do not, of course, reflect the great number of persons practising medicine without a medical qualification.⁹²

The eighteenth century trade directories contain a useful, albeit incomplete, listing of medical practitioners. In *An Index of London Surgical Practitioners, 1736-1811*, David Wright showed that prior to the publication of Mortimer's directory in 1763, which includes details of the members of the Corporation of Surgeons, references to surgical practitioners in the directories were few and infrequent.⁹³ Just over 200 "examined and approved" surgeons are listed in *Mortimer's Universal Directory 1763*. This publication remained virtually isolated until the emergence of *The Universal British Directory of Trade and Commerce* in 1790, which contains an extensive list of qualified medical practitioners.⁹⁴ The entries for the surgeons, according to Wright, may have originated from a contemporary list from the Corporation of Surgeons of London.⁹⁵ Of interest to this thesis is where these medical people set up their practices in the late 18th century. Since the fashionable areas for the beau monde were Westminster, St. James's, and Mayfair it may be that the medical practitioners were consequently drawn to these localities as a result. Table 2.1 Appendix B, shows the distribution of the practices of surgeons, apothecaries, and

⁹¹ Ernest Muirhead Little, *History of the British Medical Association*, (London, 1932), p. 5.

⁹² *Ibid.*, Little maintained that the figures for the 1841 Census showed that of the 33,339 people listed as practising some form of medicine only approximately one third, held a medical qualification.

⁹³ Wright, *Index of London Surgical Practitioners*, pp. 1-9.

⁹⁴ *Ibid.*, According to Wright, there was one other short-lived directory, *Bailey's Directory* of 1784, which also included the names of surgeons, and was derived from the Corporation of Surgeons' London list. This directory however is incomplete for the following year; 1785, as there are no details of surgical practitioners after the letter 'p.'

⁹⁵ *Ibid.*

physicians in London, as reported in the *Universal British Directory of Trade and Commerce*.⁹⁶ Although the entries contained in the *Directory* are arbitrary they do, however, provide us with an *indication* as to where the majority of practices were located.

According to Zachary Cope, “in the seventeenth and well on into the eighteenth century most consultants lived within the confines of the City of London”. Their choice of residence, Cope argued, was dictated by their need to be close to the hospitals, their patients and the College of Physicians and Company of Surgeons.⁹⁷ Cope further stated that “in the middle of the eighteenth century as London extended to the west and many new hospitals arose (Guy’s, Westminster, St. George’s and Middlesex Hospitals), a number of physicians took up residence in the new and pleasant quarters of Bloomsbury.”⁹⁸ As Raymond Crawford remarked in his 1931 Harveian Oration, “it should be remembered that in 1831 the centre of medical activity was not as now in Harley Street, but in the district adjacent to the British Museum”.⁹⁹

The data in Table 2.1, Appendix B, corroborates Cope’s findings and a number of observations can be made on the location of practices in London

⁹⁶ Source: John Wilkes, and Peter Barfoot, compilers, *The Universal British Directory of Trade and Commerce*, (London, 1790), Vol. 1, pp. 444–452. This *Directory* was used as the publication included a ‘London Street Directory’ which contained ‘an Alphabetical List of the Streets, Squares, Lanes, Courts, Alleys, & C. in London, Westminster, and Borough of Southwark, pp. 641–711. The listing for the medical practitioners did not usually contain the district in which the streets, lanes or squares were located. *The Street Directory* was therefore a useful supplement. According to this publication, the only Surgeon registered in Harley Street was Benjamin Humpage.

⁹⁷ Cope, ‘Harley Street’, p. 7.

⁹⁸ *Ibid.*

⁹⁹ Sir Raymond Crawford, ‘The Place of Medical Societies in the Progress of Medicine’, ‘Harveian Oration’ on the Occasion of the Centenary of the Harveian Society of London: 11 June, 1931, Archives of the RCP/245/2, p. 3.

by the end of the eighteenth century. Unequivocally, the biggest concentration of apothecaries, (33 per cent) surgeons (58 per cent) and physicians (40 per cent) was still in the City and Holborn. The vast majority (i.e., three-quarters) of the apothecaries were concentrated in the City, East London and Holborn. However, these areas only attracted 40% of surgeons and 41% of physicians. The data suggests that by the close of the century, Mayfair was certainly becoming a fashionable area in which to establish a practice for both surgeons and physicians. The district attracted 20% of the physicians and 11% of surgeons. Therefore, 60% of the physicians chose the City, Holborn or Mayfair as their place of business with St. James's increasingly becoming a popular area.

With the exception of the City and Mayfair, the location of surgical practices was spread more evenly across London, although it should be noted that this sector had a significantly large number of respondents with no recorded address. Marylebone had not yet fully established its reputation amongst the medical men, and Bloomsbury and Soho were just marginally more attractive to them. It must be emphasised that Table 2.1 only represents a portion of the medical practitioners. Some did not return an address for the list and for others a hospital address was given. Notably, all the apothecaries in the sample recorded a place from where they worked, either their practice or a hospital.

The Urbanisation of St. Marylebone

In 1832, Peter Potter's plan of the parish of St. Marylebone, in Plate 2.5, which emulates Richard Horwood's maps of London executed in the

1790's, illustrates how far the area had developed since Rocque's map of 1747.¹⁰⁰ In Horwood's map of the Marylebone area, the street names could easily be deciphered. The borders of individual dwellings were clearly marked and in some cases, the houses were numbered.

¹⁰⁰ Potter's , *Plan of the Marylebone Estate*, the first edition of the Map was dated 1821 and was commissioned by the order of the Vestry. See introductory notes, which accompany a reproduction of the map by Richard Bowden, Archivist, Marylebone Library for *the Saint Marylebone Society*.

Image removed due to third party copyright

Though Potter's map is similar to Horwood's, Richard Bowden maintained that the numbering is more precise than one would find on a Horwood map. On Potter's plan, the large town houses are coloured a dark shade of grey and the 'lesser dwellings,' such as the mews houses and workshops, are etched in a lighter shade.¹⁰¹ The advance in urbanisation since John Prince's plan of 1719 is obvious. The development, as it now exists, is no longer a simple geometric configuration. Regent Street has replaced Bolsover Street and Edward Street. The latter has been relegated to a narrow offshoot of Foley Place. Ogle Street has disappeared and in its stead curves Langham Place, around All Souls and through to Portland Place. Upper Harley Street is now firmly established as a continuation of Harley Street. Notably, Harley Street is no longer situated to the northeast of Cavendish Square.

On Potter's plan, the names of Chandos and Harley have been interchanged. Harley Street now runs through to Upper Harley Street, from the northwest side of Cavendish Square. It comes to a halt at the New Road, now Marylebone Road. It is interesting to ponder, if the *designata* of Price's plan had been executed, whether a Chandos Street address would have held the same cachet as a Harley Street address for the aspiring medical practitioner.

By the middle of the 1840s, Cavendish Square and the surrounding streets were becoming increasingly attractive to medical men. In 1845, nine qualified medical practitioners had set themselves up in Wimpole Street, eight in Harley Street, six in both Margaret Street and Queen Anne Street

¹⁰¹ *Ibid.*

and four in Cavendish Square itself. These were predominately physicians, the rest were GPs and surgeons.¹⁰² This compares favourably with 20 medical practitioners in Finsbury Square in the City and an additional 12 in the surrounding streets.¹⁰³ This district held the greatest concentration of medical men in London at the time and Brook Street in Mayfair was a close second with 19. Gower Street, Savile Row and Sloane Street were near contenders with 13, 11 and 13 practitioners respectively.¹⁰⁴

Establishing a practice in Harley Street became progressively more popular over the course of the nineteenth century. The following factors were examined to determine how Harley Street developed as an urban medical area: the previous location of each incumbent, the length of period of registration in Harley Street for the cohort and the dramatic rise in the number of medical practitioners up to the Great War. Finally, to what extent could the area be viewed as an indicator of increasing medical prosperity or, indeed, the acme of medical addresses in London?

Previous Practice Address

Table 2.2, Appendix B, shows that 422 medical practitioners, approximately two thirds of the male cohort, had established practices in London prior to moving to Harley Street. Just under half of the total cohort, were

¹⁰² *Medical Directory*, 1845, in Harley Street, for example, Riadore, E., and Southey, H.H., were referred to as “Physicians” Clarke, Sir C. M., was categorised as an “Obstetric Physician”, Hancock, H., as a “Surgeon”, Coles, J., as a “Surgeon – Orthopedist”, and Maclure, W., as a “General Practitioner”

¹⁰³ Sir Hermann Weber, the father of the Harley Street physician F. Parkes Weber was described as having “a fashionable practice in the 1860’s in Finsbury Square, which was then a doctors’ quarter in London”. Anon, ‘F. Parkes Weber’ *BMJ*, June 9, 1962, p. 1630.

¹⁰⁴ Information on the number of registered medical practitioners and their location was obtained from *Medical Directory*, 1845.

established in West and West Central London. The area north of Cavendish Square, between Portland Place and Marylebone High Street, was the most popular previous registered address of the group. Over a third of the cohort (36.83 per cent, $n = 242$) moved from the streets parallel and perpendicular to Harley Street. Morell Mackenzie was one of this group who relocated from nearby Weymouth Street to Harley Street. Growing prosperity encouraged him to move at the age of thirty-three to “one of the largest houses in Harley Street”.¹⁰⁵

A sizeable number ($n = 54$) arrived in Harley Street within two years of qualifying. However, the majority of these (64%) shared an address with a relation who had already established a practice in the Street. Of the entire group, 52 moved from resident posts in hospitals to a private practice in Harley Street. Most were from the London general hospitals, although 32 % ($n = 17$) of these held resident posts at specialist hospitals such as The Royal Hospital for the Diseases of the Chest, The Hospital for Sick Children (Great Ormond Street) and the Ophthalmic Hospital (Moorfields).¹⁰⁶

An analysis of the cohort's address prior to arriving in Harley Street further revealed that only 2.28 per cent ($n = 15$) of practitioners were registered at two addresses.¹⁰⁷ Dual registration increased when the cohort became established in the Street; moreover, dual registration was more

¹⁰⁵ Robert Scott Stevenson, *Morell Mackenzie: The Story of a Victorian Tragedy*, (London, 1946), p. 40.

¹⁰⁶ The number who were registered at a General Hospital prior to Harley Street are as follows: 9 St Thomas's, 7 Middlesex, 6 St Bartholomew's, 4 University College, 4 King's, and 2 at each of the following: Charing Cross, and Guy's and 1 from St George's.

¹⁰⁷ For the purpose of Table 2.2, I have taken their first address listed in the *Directory* or *Register*.

frequently recorded in the *Medical Directory* from the 1880s. Thus, in the 34 years from 1845 to 1879, 6.92 per cent ($n = 9$) of the male cohort were listed as registered at two addresses, whilst in the 34 years from 1880 to 1914 this had increased to 19.92 per cent ($n = 105$). Jane Harriet Walker, who also had a practice at Cannon Street, was the only member of the female cohort listed as registered at two addresses.

Most of these additional practices were outside Central London and, although they were positioned throughout the country, there was no preponderance of any particular county. The location of second practices spread from areas in London, such as St John's Wood to other counties in England such as Sussex. The majority of these practices were in the South East, like those of the orthopaedic surgeon, Bernard Roth who held practices in London and Brighton for 27 years, catching the train at midday to commute between the two areas.¹⁰⁸ Only a few were located in the Midlands and the North of England. Liverpool delineated the most northern extremity in the UK. Five of the cohort had overseas addresses: such as Arthur J. M. Bentley, for example, who practised in Cairo during the winter months.

Period of Registration in Harley Street

The average period for a medical practitioner to be registered in Harley Street was over 14 years; this ranged from a minimum of up to one year (10.65 per cent) to a maximum of 61 (one person only) years. The period of registration for the cohort in Harley Street is shown on Table 2. 3, Appendix B. Just over half ($n = 337$, 51.29 per cent) of the total Harley Street men

¹⁰⁸ Anon, Bernard Roth, *Lancet*, Apr. 10, 1915, p. 772.

were registered in Harley Street for up to ten years, the rest stayed for between 11 and 61 years. However, of those that stayed up to ten years, only a small number moved out of the Harley Street Area. Table 2.4, Appendix B, shows the location of the group's registered medical address after practising in Harley Street. Over three quarters of the cohort, 76.41 per cent ($n = 502$) either stayed in Harley Street ($n = 319$, 48.44 per cent) or moved to another address in the Harley Street Area. The majority retired, died or remained in this medical district; thus, Harley Street or the Harley Street Area can be viewed as the pinnacle of private practice for the majority of the cohort.

The age on arrival in Harley Street was ascertained from obituaries for almost half of the male cohort (48.55 per cent, $n = 319$) and their average age was found to be 39.¹⁰⁹ Considering that one could qualify in medicine at the age of 21 this number was used as a basis to estimate the age for the rest of the cohort: the difference between the date of their first medical qualification and the date of arrival was added to 21, which produced an approximate age on arrival in Harley Street of 34. The average age of the male cohort did not change significantly over the time-period. Almost three quarters (72.32 per cent) of the entire group were aged 30 or over, which indicated that most men would have been in practice for approximately a decade before their arrival in Harley Street.

A few of the cohort, including George Thin, practiced overseas before becoming established in the Street. Following his education at Edinburgh

¹⁰⁹ The age of the rest of the cohort could not be found from the available sources. Eight of the group who were in the *Medical Directory* 1845 were not included, as their date of arrival could not be ascertained. They may have arrived in any year up to the start of the period, 1845.

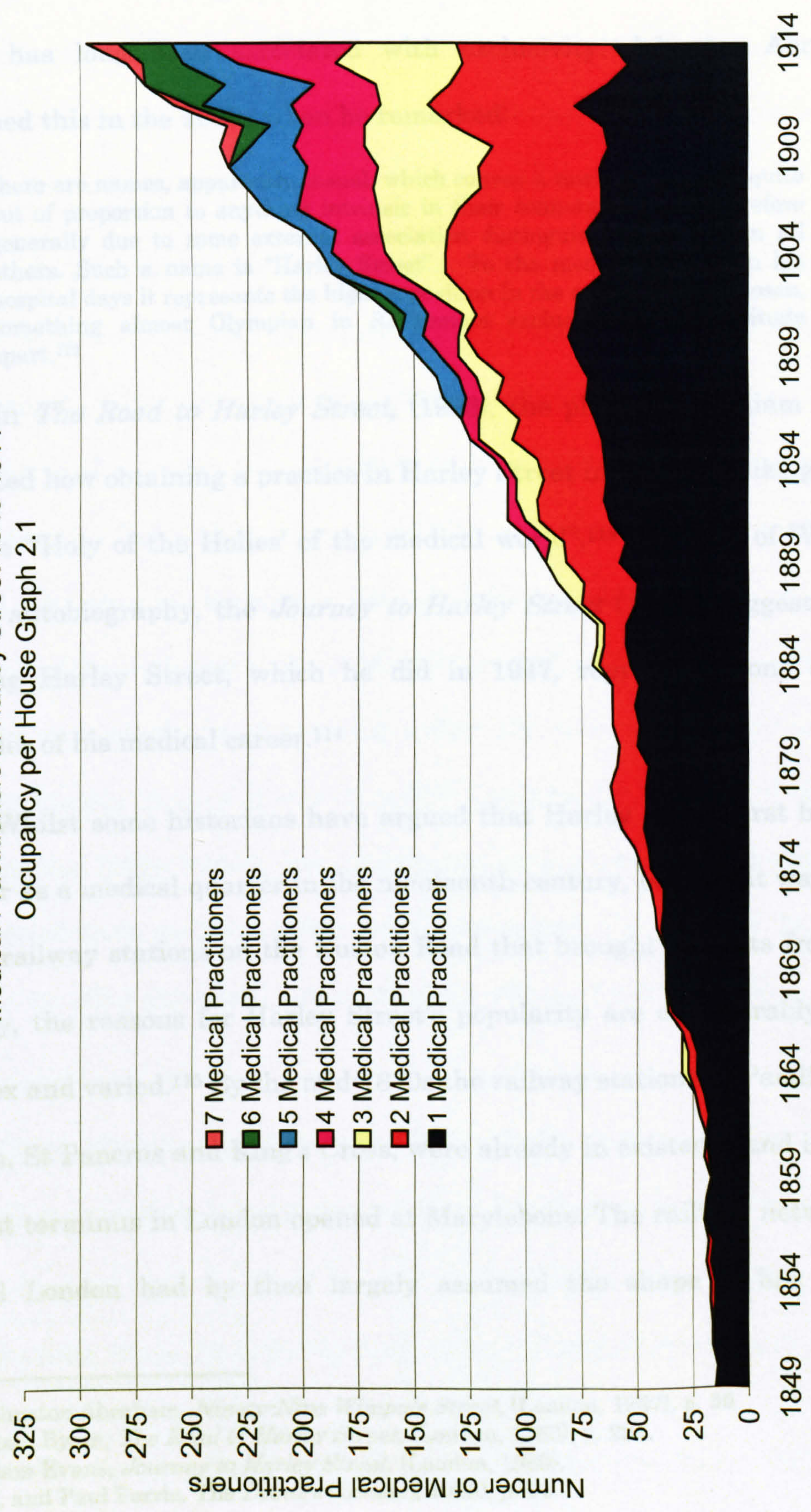
University, Thin practiced in Scotland before travelling to Shanghai where he continued his medical career.¹¹⁰ It was not until he was 58 that he established his consultancy practice in dermatology and later tropical disease in Harley Street. Because of the length of time the cohort were registered in the Street, which was on average almost 14 years for the male cohort and slightly longer for the female cohort, Harley Street can be viewed as a period of consolidation leading up to the peak of their career.

Only a minority of the cohort were sole occupiers of their houses in Harley Street. Whilst Reginald Pound claimed that, “multiple room letting and the resultant proliferation of doctors’ nameplates first began, in the early 1920s”, the data in Graph 2.1, Multiple Occupancy, revealed that multiple letting began at a much earlier date.¹¹¹ To determine the frequency of occurrence of multiple lettings, the number of medical practitioners registered ‘per house’ was calculated. From 1905, the *Directory* did not list the house number next to the person’s name in the Street List; thus, the biographical section in the *Directory* was consulted for each person. As can be seen in Graph 2.1, multiple letting was well established before the start of the Great War. In fact, by 1900 as many shared a house as were sole occupiers, and by the end of the period multiple occupancy greatly exceeded single occupancy. The first doctors to share a practice address in Harley Street in 1853 were father and son, Edward and Henry Monro.

¹¹⁰ W.F. Bynum and Caroline Overy, eds., *The Beast in the Mosquito: the Correspondence of Ronald Ross & Patrick Manson*, (Amsterdam, 1998), p. 505.

¹¹¹ Reginald Pound, *Harley Street*, (London, 1967), plate between pp. 78 and 79.

Medical Practitioners in Harley Street 1848-1914
Occupancy per House Graph 2.1



Why Harley Street?

The reasons for choosing to set up a practice in Harley Street were varied, but it has long been associated with exclusivity. Johnston Abraham confirmed this in the 1930s when he remarked:

there are names, apparently casual, which convey a world of meaning quite out of proportion to anything intrinsic in their connotation, and therefore generally due to some external association distinguishing them from all others. Such a name is "Harley Street"... To the medical student in his hospital days it represents the highest position in the calling he has chosen, something almost Olympian in its remote exclusiveness, an altitude apart.¹¹²

In *The Road to Harley Street*, (1963), the physician William Byam recounted how obtaining a practice in Harley Street in 1921 was like getting into the "Holy of the Holies" of the medical world.¹¹³ The title of William Evans' autobiography, the *Journey to Harley Street* (1968), suggests that reaching Harley Street, which he did in 1947, represented one of the pinnacles of his medical career.¹¹⁴

Whilst some historians have argued that Harley Street first became popular as a medical quarter in the nineteenth century, because it was close to the railway stations on the Euston Road that brought patients from the country, the reasons for Harley Street's popularity are considerably more complex and varied.¹¹⁵ By the mid-1870s the railway stations at Paddington, Euston, St Pancras and King's Cross, were already in existence and in 1899 the last terminus in London opened at Marylebone. The railway network of central London had by then largely assumed the shape it has today.

¹¹² J. Johnston Abraham, *Ninety-Nine Wimpole Street*, (London, 1937), p. 55

¹¹³ William Byam, *The Road to Harley Street*, (London, 1963), p. 227.

¹¹⁴ William Evans, *Journey to Harley Street*, (London, 1968).

¹¹⁵ *Ibid.*, and Paul Ferris, *The Doctors* (London, 1965), p. 24.

According to Irvine Loudon's article on doctors and their transport, the train had a considerable effect on consulting practices. With doctors' travelling times reduced, more patients could be seen.¹¹⁶ In addition, the rail system also facilitated more referrals to Harley Street consultants, as there were at the time, few well-known consultants in the provinces.

Abraham pondered that, "there seems to be no particular reason why [Harley Street] should ever have originated, or why, once started, it should still remain".¹¹⁷ Yet, he was aware of the westward move by the wealthy merchants and the aristocracy from the City to Covent Garden, Bloomsbury and then on to Oxford Street by the middle of the nineteenth century. The medical practitioners wishing to attend these individuals likewise moved westward. Due to hospital regulations, the staff of the London teaching hospitals were required to live within a short distance, so that they could be called in quickly in case of emergency.¹¹⁸ Undoubtedly, the use of the car, from the late 1890s freed a few consultants from the hospital environment and allowed them access to a larger catchment area. Car use was, however, limited: by 1913 only one person in every 165 in Britain owned a motor car.¹¹⁹

When Charles Heanley, consulting plastic surgeon to the London Hospital was writing his reminiscences of the Harley Street surgeon Sir

¹¹⁶ Irvine Loudon, 'Doctors and their Transport, 1750-1914', *Medical History*, April, 2001, p. 13

¹¹⁷ Abraham, *Wimpole Street*, p. 57

¹¹⁸ *Ibid.*, pp. 57-58.

¹¹⁹ Trevor May, *An Economic and Social History of Britain, 1760-1990*, (Essex, 1996), p. 318.

Henry Souttar in 1996, he described how Souttar and other consultants were paid a sum of £50 per annum by the London Hospital. This was referred to as “cabbage” – money given to them for transport from their West End consulting rooms in Harley Street” to the hospital.¹²⁰ Whilst some arrived at the hospital by public transport: the train, tram, bus and later the tube others, such as Theodore Thompson, arrived in a Rolls Royce.¹²¹

The proximity of the cohort’s hospital posts was not the only issue in deciding whether to establish a practice in Harley Street: an analysis of their staff posts showed that they held appointments across a range of 526 different medical institutions both inside and outside London. When the location of these hospitals were examined, it was found that they were widely dispersed across London: Bart’s, for example, which had the greatest affiliation of the group, lay in West Smithfield, whereas St. George’s Hospital was at Hyde Park Corner and Westminster Hospital was near Westminster Abbey. It thus seems likely that the location of the teaching hospitals played a small role in the development of Harley Street as a medical centre.

Graph 1.1 Harley Street on page 28, shows the increase in the number of medical practitioners during the period. There was a steady increase in numbers up to 1885, and then from this point until 1914, the rise is exponential. Had the growth continued on the same trajectory as that to 1885, the total number would have been approximately 120, in fact, the

¹²⁰ Charles Heanley, ‘Reminiscences of Sir Henry Souttar’ *The London Hospital Gazette*, Medical and Dental Clubs Issue’, no. 21, 1996, pp. 9-10.

¹²¹ *Ibid.*

number was 298.¹²² This rise was a reflection of the growth in the population of London during the period. In 1871, for example, the population of Greater London was 3,900,000 by 1901 it had increased to 6,600,000.¹²³ Concomitant with the increase of medical practitioners in Harley Street were medical practitioners throughout Greater London who numbered 2,027 in 1845, which increased to 3,947 in 1880 and swelled to 6,694 in 1914.¹²⁴ The rising professionalisation of medicine and the subsequent growth of specialisation, along with the new academic disciplines during this time played, no doubt, a role in the formation of a geographical location where professionals worked side-by-side in the same area.¹²⁵

Whilst medical students pursued their qualifications in medical schools within various universities, which was followed by training undertaken in hospitals, those medical practitioners who chose the life of a consultant did not necessarily have the same geographical locus or institutional affiliation they had when they were at university or training in hospitals. For the medical consultant who had achieved prominence, partly due to their initiative in creating new specialities and because they were regarded as experts in their chosen area, congregating in one street may

¹²² This figure included 17 women and three men who had retired from practice.

¹²³ Chris Cook, *Britain in the Nineteenth Century, 1815-1914*, (London, 1999), p. 114.

¹²⁴ Totals from the 1880 and 1914 *Medical Directory*. Own count from the 1845 *Medical Directory*.

¹²⁵ For a discussion on the development of professionalisation and the increase in demand for medical care see Ivan Waddington, *The Medical Profession in the Industrial Revolution*, (Ireland, 1984), J.B. Morrell, 'Professionalisation' in R.C. Olby, G.N. Cantor, J.R.R. Christie and M.J. Hodge, eds., *Companion to the History of Science*, (London, 1996), pp. 980-989 and Harold Perkin, *the Rise of Professional Society, England since 1880*, (London, 1989).

have provided the opportunity to maintain a degree of professional community that they had experienced previously at university and in hospitals. Other factors that account for this rise are detailed below.

An improved communication network enhanced the referral system and decreased the travelling time for both the doctor and the patient. The invention of the telephone in 1876 allowed access to a wider client base and as a result increased business for the Harley Street consultant. It was not until 1901 when the telephone was widely used that it became possible for consultants to have a practice in Harley Street a couple of days a week in addition to a practice elsewhere. They no longer had to be on site to deal with problems or issues. All of this meant increased business for the medical profession in Harley Street and arguably an increased demand for consulting rooms. The convenience of Harley Street's central location, near most of the major hospitals and train stations and the use of the motorcar are some, but not all, of the reasons for the Street's popularity. Commentators have overlooked the importance of social and professional connections, family relations and the eminence of medical practitioners who could attract new inhabitants to the area.

The snob appeal of Harley Street as an address was already established when the medical charlatan Mr John St. John Long (1798-1834) began to treat society ladies there in the 1820s. He claimed to be able to cure consumption and distinguish between "sound and unsound tissues" through the medium of a lotion that he invented. He then:

took a large house in Harley Street, and fitted it up for the reception of people anxious to consult him; and for some seasons every morning and afternoon (from 8 a.m. to 4 p.m.) the public way was blocked up with carriages pressing to his door. The old and the very young alike flocked to him; but nine of his patients out of every ten were ladies.¹²⁶

St. John Long had “rooms handsomely fitted up ... elegant waiting-rooms matched the grace and polish of his patients”.¹²⁷ He had a highly lucrative practice and his income has been estimated as £13,000 in 1829.¹²⁸ Part of the reason for his success was attributed to the location of his practice because “a good address and a considerable quantity of intellect ... distinguished him from the vulgar herd of cheats”.¹²⁹ Even though the deaths of Catherine Cushin in 1830 and soon after Mrs Colin Campbell Lloyd have been attributed to him, St. John Long retained the patronage of many of his wealthy patients.

When the physician Jukes De Styrap advised young practitioners wishing to establish a private practice in the 1880s, he urged them to acquire “a good address”.¹³⁰ Harley Street would have been one such location, since it was viewed by then as “the Mecca of the profession” by the aspiring and ambitious consultant.¹³¹ However, a Cavendish Square address was more desirable than one in Harley Street. The closer one’s practice was to Cavendish Square, the more prestigious was one’s address; thus, the lower numbers in the Street were the most sought-after. Sir Alfred Garrod

¹²⁶ J. Cordy Jeaffreson, *A Book about Doctors*, (London, 1861), p. 227

¹²⁷ Eric Jameson, *The Natural History of Quackery*, (London, 1961), p. 68

¹²⁸ Juanita Burnby, *Caricatures and Comments*, (Staines, 1989), p. 5.

¹²⁹ Jeaffreson, *Doctors*, p. 225. Qualified medical practitioners derided St John Long and Wakley denounced his quackery in the *Lancet*. See Roy Porter, *Quacks, Fakers and Charlatans in English Medicine*, (Gloucestershire, 2000), p. 194.

¹³⁰ Jukes De Styrap, *The Young Practitioner*, (London, 1889), p. 21

¹³¹ J. Purves – Stewart, *Sands of Time: Recollections of a Physician in Peace and War*, (London, 1939), p. 50.

for example, who had lived at number 84 Harley Street, moved to number 10 in 1874, to be “nearer to Cavendish Square”.¹³²

Harley Street was regularly associated with ambitious young medical practitioners lured by the Street’s eminent men and the possibility of sharing in the Street’s prosperity. Thus, when James Purves-Stewart had secured a position as a junior hospital physician at Westminster Hospital, like “every ambitious young medical man at the time”, he set out to find consulting rooms in Harley Street. In 1900, he managed to secure a consulting room with a small bedroom attached. The house was not close to Cavendish Square since it was “the far end” of the Street. Purves-Stewart gradually built a successful consultancy practice as a neurologist and later acquired rooms at the “near end: one door away from Cavendish Square”.¹³³ Likewise, Sir Henry Thompson, who was also “not without some ambition” took a seven-year lease in Wimpole Street prompted by his colleague at UCH, George Harley who recommended the Harley Street Area to him.¹³⁴

George Harley’s daughter who edited his account of *Life as a London Physician*, described her father, when he set up practice in Harley Street in 1860, as entering the doctors’ “Elysium”.¹³⁵ George Harley chose Harley Street because “excepting Portland Place, [it was] the first really good street going west”. He also had family associations there and the Street was within

¹³² Anon, ‘Sir Alfred Baring Garrod’, *BMJ*, Jan. 4, 1908, p. 58.

¹³³ Purves-Stewart, *Sands of Time*, p. 97.

¹³⁴ His colleague at UCH was probably George Harley. W. R. Merrington, *University College Hospital and its Medical School: a History*, (London, 1976), pp. 71 and 83. See also Mrs Alec. Tweedie, (ed.) *George Harley F.R.S. or the Life of a London Physician*, (London, 1899), p. 133.

¹³⁵ Tweedie, *Harley*, p. 133.

15 minutes walk of University College London, where he had been appointed Professor of Medical Jurisprudence in 1859. The prestige of the aristocracy and of titled members of the medical profession was also an important factor, which Harley noted when he moved into the house once occupied by Baroness Burdett-Coutts during her childhood.¹³⁶ His neighbours included Sir William Jenner, Sir John Williams, Sir Alfred Garrod and Sir Richard Quain. Edward Collett Hort, who bought a practice in Torquay in 1907, found that when he moved to Harley Street in 1909, he immediately developed a “high-class practice” specialising in bacteriology and, in particular, immunology.¹³⁷

Some consultants, such as William Francis Victor Bonney wanted to move to larger premises, yet remain in the Harley Street Area. Bonney shared rooms at 15 Harley Street with three other medical practitioners, including his friend, the eminent surgeon Sir Gordon Gordon-Taylor.¹³⁸ When a house became available at 29 Devonshire Place in 1911, “with consulting rooms on the ground floor and living quarters above”, Bonney took over the lease.¹³⁹ Similarly, after Gordon Holmes was appointed consultant to Moorfields Eye Hospital and Charing Cross Hospital, he established a private practice at 58 Harley Street in 1911. When he married in 1918, however, needing larger premises for entertaining and his burgeoning consultancy practice, he moved to the adjoining Wimpole Street

¹³⁶ *Ibid.*

¹³⁷ Anon, ‘Edward Collett Hort’, *BMJ*, Oct. 21, 1922, p. 777.

¹³⁸ Geoffrey Chamberlain, *Victor Bonney: the Gynaecological Surgeon of the Twentieth Century* (London, 2000), p. 21.

¹³⁹ Chamberlain, *Bonney*, p. 130.

where he had “a large house over five floors which required a permanent staff of nine servants”.¹⁴⁰

The houses in Harley Street were in varying states of repair. Some incumbents such as the ophthalmic surgeon, Walter Jessop, decided to refurbish their premises prior to their renewal of their lease. In 1903, Jessop’s lease had terminated and in his determination to rebuild the premises, he took to scouring the neighbourhood for “Adam’s mantelpieces whenever a house was to be pulled down, and in this he was often successful”.¹⁴¹ Despite the illustriousness of many of the Street’s inhabitants, Harley Street was not immune to such health hazards as typhoid. In 1873, an outbreak occurred in London and Mrs William Squire, who was on vacation in Paris, received a letter from one of the inhabitants of Portman Square in London. The writer described how parts of West London were in a poor state of health:

in consequence of a very large number of typhoid cases ... I am afraid Dr Squire will find many of his colleagues whose households have suffered the fever ... principally about Harley Street, Cavendish Square ... it is considered that the drains hereabouts would be very dangerous.¹⁴²

Familial connections often played a decisive role within the medical profession.¹⁴³ Whilst Peterson claimed that, “systematic data on the social origins of medical men of all ranks are not available” and that records exist only for FRCPs, FRCSs and LSAs she overlooked such sources as Venn’s

¹⁴⁰ Davis Coakley, *Irish Masters of Medicine*, (Dublin, 1992), pp. 259-260.

¹⁴¹ F. W. Andrews, W. McAdam Eccles, G.E. Gask, W.D. Harmer, H. Thursfield, and H. Williamson eds., *Saint Bartholomew’s Hospital Reports*, (London, 1920), Vol. Liii, 1917 and 1918, pp. 2-3.

¹⁴² Quoted in Merrington, *University College Hospital*, pp. 54-55.

¹⁴³ Irvine Loudon, *Medical Care and the General Practitioner: 1750-1850*, (Oxford, 1986), pp. 34, 201.

Alumni Cantabrigienses and obituaries.¹⁴⁴ Nevertheless, there were problems associated with some available sources; *The Oxford Calendar*, for example, listed only the students' degrees and year of qualification, but none of the personal information relating to a student, whilst obituaries frequently provided the name but not the occupation of the father.

Peterson found that "the most common background for the Victorian medical student was that of a medical family."¹⁴⁵ Parental occupation was ascertained for a quarter of the Harley Street cohort and it was found that less than half of these (43.78 per cent) came from medical families. Parental occupation determined for the rest of the cohort showed that they came from a range of backgrounds; the next dominant group were the clergy, followed by the law, civil servants, merchants and businessmen, academics and other professions such as accountants.

A fifth of those whose social background had been established had a brother or father who was a Harley Street man.¹⁴⁶ Some, such as the dermatologist James Harry Sequeira and William McAdam Eccles, came from a long line of doctors; five generations of Sir Buckston Browne's family had been doctors.¹⁴⁷ Robert Fortescue Fox was the youngest of seven sons of the surgeon Joseph John Fox all of whom went into medicine.¹⁴⁸ There were many instances where a young medical practitioner shared a consulting

¹⁴⁴ John Venn and J. A. Venn, *Alumni Cantabrigienses*, (Cambridge, 1922-1954).

¹⁴⁵ M. Jeanne Peterson, *The Medical Profession*, (London, 1978), p. 41 and Table 9 p. 198.

¹⁴⁶ Parental Occupation was found for 25.72 per cent of the Harley Street cohort ($n = 169$).

¹⁴⁷ 'Sequeira, James Harry', *Munk's Roll*, 1905, Vol. IV, p. 467 and Anon, 'William McAdam Eccles', *BMJ*, 15 June, 1946, p. 892. Anon, Sir Buckston Browne, *BMJ*, Jan. 27, 1945, pp. 132-133.

¹⁴⁸ Anon, 'R. Fortescue Fox', *BMJ*, June 29, 1940, p. 1072.

room with a relative who was already established in the Street.¹⁴⁹ Having qualified MRCS, LRCP in 1889, Alfred Downing Fripp was appointed Demonstrator of Anatomy at Guy's in the following year. Fripp was nearly 25 when his brother-in-law Dr. Hale-White offered him a consulting room at 65 Harley Street. As his biographer remarked, "a Harley Street address [was] invaluable to a young doctor of ambition".¹⁵⁰ When Duncan Maclure's father William died, Duncan took over his father's practice in Harley Street in 1852.¹⁵¹

Connections within the cohort were important and in some cases changed the course of a medical practitioner's career. When Frederick William Price arrived in London, having graduated from Edinburgh University, he took the position of assistant medical officer at the Brompton Hospital. But it was through his interest in cardiology, which was fostered by his association with the eminent cardiologist, Sir James Mackenzie, that he became interested in the subject. James Mackenzie had moved from his G. P. practice in Burnley, Lancashire to Bentinck Street in 1907. Although he would have preferred a Harley Street address he was reluctant to take on a long lease there until he had established himself in London.

A year later, with Price's recommendation, Mackenzie joined the staff of the Mount Vernon Hospital, Hampstead and later took a room at Price's

¹⁴⁹ Fathers and sons in Harley Street included Vaughan Harley, son of George Harley, Harry Arthur Sansom, son of Arthur Ernest Sansom, William Soltau Fenwick son of Samuel Fenwick, Henry Gervis son of Henry Gervis and John Edward Squire son of William Squire.

¹⁵⁰ Cecil Roberts, *Alfred Fripp*, (London, 1932), p. 51.

¹⁵¹ Anon, 'Duncan M. Maclure', *Lancet*, Jan. 3, 1880, p. 34.

house in Harley Street. Mackenzie's biographer Alex Mair remarked on the Street's "magic name", and maintained that by 1910-12 Mackenzie had built a celebrated practice, where he treated such a large number of the aristocracy that "his diary reads like an edition of Burke's Peerage".¹⁵² So great was Mackenzie's allure that following his retirement, Price occupied Mackenzie's vacant room and his practice was said to have increased because of this association.¹⁵³

Some moved to Harley Street because they were invited to become partners or assistants to medical practitioners who were already established there. Samuel Ernest Dore had worked with the skin specialist, Sir Malcolm Morris, in the skin department of St Mary's, and in 1903 he moved to Morris's practice, number 8 Harley Street. In the following year, Dore established a practice of his own in the nearby Wimpole Street.¹⁵⁴

Whilst George Buckston Browne was a demonstrator of anatomy at UCH in the late 1870s, he met Sir Henry Thompson who was then consulting surgeon to the hospital. Thompson later invited Browne to become his assistant, and then partner, at his "fashionable practice in Wimpole Street".¹⁵⁵ Browne went on to establish his own successful practice in Harley Street from 1878, specialising in diseases of the urinary tract. The surgeon, Herbert Thomas Herring, whose special interest was also disease

¹⁵² Alex Mair, *Sir James Mackenzie, M.D., General Practitioner, 1853-1925*, (London, 1973), pp. 238-39

¹⁵³ Anon, 'F.W. Price', *BMJ*, March 30, 1957, p. 765.

¹⁵⁴ Anon, 'Samuel Ernest Dore', *Lancet*, July 8, 1950, p.78.

¹⁵⁵ *Ibid.*, Sir Henry Thompson's octave dinners: "8 persons, with 8 courses, at 8 o'clock" were famous social occasions occasionally attended by Royalty.

of the urinary tract, assisted Thompson in his private practice (from 1888) before establishing a practice in Harley Street in 1891.

Many of the group had formed friendships with each other at university or medical school, which continued throughout their period in Harley Street. Three King's College Hospital alumni, John Charlton Briscoe, George Lenthal Cheate and Arthur Whitfield shared a research laboratory in Harley Street.¹⁵⁶ Herbert Ritchie Spencer met Sir Dawson Williams at UCH and they formed "a life long friendship" which established "a link between the *British Medical Journal* ... and University College Hospital".¹⁵⁷ Williams established a practice in the Street in 1896 and Spencer followed him there three years later. Thus, when Dawson was editor of the *BMJ*, Spencer contributed several articles to the *Journal* on obstetrics and the history of medicine.¹⁵⁸

The Success of a Harley Street Practice

Consideration was given to exploring whether a Harley Street address was an indicator of achievement within the medical arena. Whilst it was not possible to ascertain the entire cohort's income or profit from private practice, a prosperous reputation could be ascertained by adopting James Paget and Squire Sprigge's hierarchical system of success. They regarded a private practice as the most significant indicator of a consummate career, which led them to classify the "distinguished success" of their peers by obtaining: 1) a leading position in a practice in great cities, 2) a place on the

¹⁵⁶ Anon, 'John Charlton Briscoe', *Lancet*, Mar. 5, 1960, p. 554.

¹⁵⁷ Anon, 'Herbert Spencer', *BMJ*, Sept. 13, 1941, p. 389

¹⁵⁸ *Ibid.*

honorary staff of a large hospital and 3) an academic chair or 4) some important public office. As Bill Bynum observed, however, achieving any of the latter three was unlikely except in conjunction with a private practice.¹⁵⁹

For those who could survive the half dozen or so years of relative hardship in building up a consulting practice, the financial rewards could be substantial:

a man might expect to take between five and seven years to establish a viable consulting practice and these years of struggle and striving would be spent in relative poverty.¹⁶⁰

During this time, paid hospital work, teaching or locum fees were important to the fledging consultant.¹⁶¹ A hospital post was virtually *de rigueur* for any medical practitioner who had ambitions to become a successful Harley Street consultant. Sir George Buckston Browne was one of the few surgeons who built up a large and successful consultancy practice first in Harley Street and later in Wimpole Street without having a hospital appointment. His biographers related that when Browne was sitting near an open window at his house in Wimpole Street in 1900, he heard a passer-by proclaim to his companion, "Buckston Browne's house. He has done it all without a hospital appointment".¹⁶² Being a member of the permanent or visiting staff of a hospital was regarded at the time as essential to keep abreast of new operating procedures and developments in medicine.¹⁶³

¹⁵⁹ W. F. Bynum, 'Medical Values in a Commercial Age', in T.C. Smout, (ed.) *Victorian Values*, (Oxford, 1992), p. 156.

¹⁶⁰ O. Connor Ward, *John Langdon Down: 1828-1896: A Caring Pioneer* (London, 1998), p. 27.

¹⁶¹ *Ibid.*

¹⁶² Jessie Dobson and Sir Cecil Wakeley, *Sir George Buckston Browne*, (London, 1957), p. 127

¹⁶³ *Ibid.*

Success in private practice did not always depend on family money. John Langdon Down, who was described by his biographer as “one of the famous medical men in a golden age of London medicine” and “a figure of society”, started life with no capital and yet eventually became “one of London’s wealthiest doctors”.¹⁶⁴ Most of the obituarists of the cohort remarked on the success of these men in private practice. George Nixon Briggs, surgeon to the Ear, Nose and Throat Hospital, had, for example, a “very busy private practice” while Sir Henry Trentham Butlin, surgeon to St. Bartholomew’s Hospital, “had acquired a lucrative practice”.¹⁶⁵ Samuel Fenwick’s “large private practice” was partly the result of having a series of dressing rooms at his Harley Street house “in which he was able to examine patients after recording the notes of their cases, by this means he was able to attend to three patients at a time”. Fenwick continued his burgeoning practice up to the age of 82.¹⁶⁶ The diligence (and perhaps avarice) of the successful Harley Street élite is exemplified by Lord Horder’s remark: “I would treat Beelzebub himself if he came into my consulting-room”.¹⁶⁷

The Social Élite: Court Physicians and Surgeons

Physicians and Surgeons to the Court were considered, both socially and professionally, to be at zenith of their careers and these included a number from Harley Street. These positions not only enhanced the status of these individuals amongst their peers, but elevated their status in society and

¹⁶⁴ Ward, *Down*, pp. xvii and 1.

¹⁶⁵ Anon, ‘George Nixon Biggs’, *BMJ*, Nov. 25. 1922, p. 1049. Anon, ‘Sir Henry Trentham Butlin’, *BMJ*, Feb. 3, 1912, p. 276. Others included Joseph John Perkins and Victor Bonney.

¹⁶⁶ Anon, ‘Samuel Fenwick’, *BMJ*, Dec. 27, 1902, pp. 1973-74.

¹⁶⁷ Anon, ‘Lord Horder of Ashford’, *BMJ*, Aug 27, 1955, p. 565.

thereby increased their earning power: the financial rewards could be significant. Sir William Jenner, physician to Queen Victoria (1819-1901), amassed a fortune of £375,000; Sir Oscar Clayton's will was proved at more than £150,000 in personal property and Sir Richard Quain left £117,000.¹⁶⁸

Many of the prominent members of the medical profession registered in Harley Street achieved fame and celebrity in their practices; both Henry Herbert Southey and Sir Charles Mansfield Clarke were Royal Physicians. Southey, an authority on lunacy and examiner of lunatics at the Court of Chancery, was Physician-in-Ordinary to George IV (1762-1830).¹⁶⁹ Clarke was appointed physician to Queen Adelaide (1792-1849), in 1830, receiving a baronetcy the following year.¹⁷⁰

Queen Victoria (1819 - 1901, reigned 1837-1901)

Queen Victoria's medical attendants consisted of a hierarchical chain of command, which ran from the Physicians-in-Ordinary and the Sargeant Surgeons down to Physicians and Surgeons Extraordinary, followed by a physician and surgeon to the household and a resident physician, finally there were the Apothecaries. There were two or three each of Physicians-in-Ordinary and Sargeant Surgeons; these were paid appointments whilst the Physicians and Surgeons Extraordinary were honorary positions.¹⁷¹ From

¹⁶⁸ A. M. Cooke in *The History of the Royal College of Physicians of London*, Vol. 111, (Oxford, 1972), pp. 893-894 and p. 894, fn. 1 and Anon, 'Medical News', *BMJ*, March 26, 1892, p. 688.

¹⁶⁹ Anon, 'Dr. Southey', *BMJ*, June 17, 1865, p. 629.

¹⁷⁰ Anon, 'Sir Charles Mansfield Clarke', *BMJ*, 12 Sept. 1857, pp.774-75 and *Munks' Roll*, 1835-36, p.13

¹⁷¹ For details of remuneration for Royal physicians and surgeons, see Rivington, *Medical Profession*, p. 331.

1864, the apothecaries usually had the combined LSA and MRCS, thus becoming Surgeon Apothecaries.¹⁷²

Surgeon Apothecaries were appointed to the Queen at Osborne and for the household at Windsor. Victoria also employed a surgeon oculist, a surgeon dentist and a dentist to the household in addition to chemists and druggists in ordinary. Additionally, Royal physicians, surgeons, dentists, oculists and apothecaries attended the Queen in Scotland and Ireland. Physicians, surgeons, apothecaries and dentists were appointed on a lesser scale to the households of the Prince and Princess of Wales, the Duke and Duchess of Edinburgh and the Duke and Duchess of Connaught, the Prince and Princess Christian and Princess Beatrice and Prince Henry of Battenberg.¹⁷³

A.M. Cooke listed the members of the Royal Medical household and found that there were 28 Physicians-in-Ordinary and Physicians Extraordinary appointed between 1837 and 1899. Four were from Harley Street: Sir James McGrigor, Sir William Jenner, Sir Richard Quain and Sir Alfred Baring Garrod. In addition, George Lawson was appointed Surgeon Oculist to the Queen and Thomas Granger Stewart acted as her Physician in Ordinary whilst she was in Scotland. The naval surgeon William Harris Lloyd, who represented the Admiralty in various scientific congresses was appointed honorary surgeon to the Queen in 1894.¹⁷⁴ William Hickman

¹⁷² A. M. Cooke, 'Queen Victoria's Medical Household', *Medical History*, Vol. 26, 1982, pp.310.

¹⁷³ Medical practitioners to the Court are listed in the *Medical Directory* from 1894 onwards.

¹⁷⁴ Anon, "Deaths in the Services", *BMJ*, April 14, 1923, p. 665.

became Surgeon in Ordinary to the Duke of Edinburgh (1837) whilst Sir John Williams was Physician Accoucheur to Princess Beatrice (1861).

McGrigor who was Physician Extraordinary to the Queen had served as Director-General of the medical department in the army.¹⁷⁵ He is best known as the "Father of the R.A.M.C." and the Duke of Wellington's Surgeon-General.¹⁷⁶ Garrod who was appointed to the Royal Household in 1890, was a consulting physician to King's College Hospital and well known for his work on the chemical pathology of gout.¹⁷⁷ Whilst Quain was

for half a century ... physician of 'Society', especially in its upper strata and its literary and artistic circles. His patients were legion and included the most influential men of their day — men like the late Mr. Delane of the Times, Mr. Carlyle, and Lord Beaconsfield.¹⁷⁸

Jenner was generally recognised as one of the leading physicians in London where he established a large and very successful consulting practice. He was appointed Physician-Extraordinary to the Queen in 1861, gazetted Physician-in-Ordinary the following year and "for a quarter of a century remained Her Majesty's most trusted adviser".¹⁷⁹ Jenner looked after the medical affairs of the Royal Family, including Albert Edward, the Prince of Wales (1841-1910, crowned Edward VII in 1901) during his near fatal illness of typhoid in November 1871. In 1864, Jenner was elected

¹⁷⁵ Anon, 'the late Sir James McGrigor', *BMJ*, April 10, 1858, p. 296.

¹⁷⁶ Richard L. Blanco, *Wellington's Surgeon General: Sir James McGrigor*, (Durham, 1974), see also Sir James McGrigor, Mary McGrigor, (ed.) *The Scalpel and the Sword: the Autobiography of the Father of Army Medicine*, (Dalkeith, [Scotland], 2000).

¹⁷⁷ There was a resident physician at Balmoral and at Windsor who did not practice privately. McGrigor, (ed.) *The Scalpel*, pp. 313-19. Edmund Alexander Parkes would have been appointed physician to the Queen, however, ill health prevented him from accepting the role. See Anon, 'Professor Parkes', *Lancet*, Mar. 25, 1876, p.480. Anon, 'Sir Alfred Baring Garrod', *BMJ*, Jan. 4, 1908, p. 58.

¹⁷⁸ Anon, 'Sir Richard Quain', *Lancet*, Mar. 19, 1898, p. 798.

¹⁷⁹ Anon, 'Sir William Jenner', *BMJ*, Dec. 17, 1898, pp. 1849-50.

Fellow of the Royal Society, and later awarded a baronetcy. He also served as President of the Royal College of Physicians (1881-88).

There were no other surgeons attending Queen Victoria who had practices in Harley Street with the exception of George Lawson. Lawson was regarded as one of Europe's leading authorities on injuries to the eye and it was on Jenner's recommendation that he was appointed Surgeon-Oculist in Ordinary to the Queen. Lawson attended the Queen's son-in-law, HRH Prince Christian (1831-1917) when he incurred an injury to his eye whilst out shooting.¹⁸⁰ In 1886, Jenner also recommended John Williams to Queen Victoria to attend her youngest daughter Princess Beatrice of Battenberg (1857-1944), who was expecting her son Alexander (née Prince of Battenburg, he took the name Mountbatten in 1917) in November 1886. Williams later became Physician Accoucheur to Queen Mary (1867- 1953) and attended the birth of Edward, the Prince of Wales (1894-1972, in 1936 King Edward VIII).¹⁸¹ Queen Victoria also appointed honorary physicians and surgeons, and some were Harley Street practitioners such as the naval surgeon William Harris Lloyd.¹⁸²

Edward VII (1841-1910, reigned 1901-1910)

Sir Alfred Fripp senior surgeon to Guy's Hospital had a long association with the Royal family that began with Albert, 5th Duke of Clarence (1864-1892), Queen Victoria's grandson in 1890. Whilst Fripp was in *locum tenens*

¹⁸⁰ Anon, 'George Lawson', *BMJ*, Oct. 17, 1903, pp. 1019-1021.

¹⁸¹ Ruth Evans, *John Williams: 1840-1926*, (Cardiff, 1952), p. 45 and Anon, 'Sir John Williams', *BMJ*, May 29, 1926, p. 922.

¹⁸² Anon, 'William Harris Lloyd', *BMJ*, Apr. 14, 1923, p. 665.

for Dr. Jalland at York he met the Duke, who was stationed at York barracks and was one of Jalland's patients. Sir Oscar Clayton of Harley Street and Extra Surgeon to Albert Edward, the Prince of Wales (Edward VII) and Surgeon in Ordinary to Alfred, the Duke of Edinburgh (1844-1900), was called in "to vet" the young Fripp.¹⁸³ He approved and Fripp proceeded to Scotland to where the Duke was recuperating from a dislocated ankle.¹⁸⁴ Fripp's attendance on the Duke and subsequently on Queen Victoria and the Prince of Wales, earned him the nicknames "The Baron" and "My Friend the Prince" at Guy's Hospital.¹⁸⁵ In 1897, Fripp was appointed Surgeon-in-Ordinary to the Prince of Wales and reappointed when the Prince was crowned King Edward VII. He later became Honorary Surgeon to George V.¹⁸⁶ He was awarded the CB and CVO in 1902 and two years later was knighted and received the KCVO.

Several Harley Street men held prominent positions in King Edward VII's medical staff. Lord Horder of Ashford had treated Edward VII's appendiceal abscess in 1901 (which was operated on by Sir Edward Treves in 1902) and became a popular Royal physician with a thriving practice in Harley Street, which he maintained from 1902 to 1946. Others included Sir Anderson Critchett who was Surgeon-Oculist and William Harris Lloyd who was an Honorary Surgeon to Edward VII from 1901. William Watson Cheyne, Professor of Surgery at King's College and surgeon to King's College Hospital was created baronet in 1908 and appointed Honorary

¹⁸³ Anon, 'Sir Oscar Clayton', *Lancet*, Jan. 30, 1892, p. 285.

¹⁸⁴ Cecil Roberts, *Alfred Fripp*, (London, 1932), p. 31

¹⁸⁵ Anon, 'Sir Alfred Fripp', *BMJ*, Mar. 8, 1930, p. 473.

¹⁸⁶ *Ibid.*

Surgeon in Ordinary to King Edward VII. Whilst, Sir William MacCormac was sergeant to Edward VII when he was Prince of Wales and was later appointed honorary sergeant-surgeon when he became King Edward VII.¹⁸⁷

Two years after Bertrand Edward Dawson left Harley Street, he was appointed physician-extraordinary to Edward VII in 1907. By then, Dawson had created a prosperous practice, and he remained in the Harley Street Area, taking a house in Wimpole Street. Dawson's connection with the Royal family was sustained through the appointment of Physician-in-Ordinary to George V, moreover, it was Dawson who signed the bulletin in 1936, which informed the country that "the King's life was drawing peacefully to its close". He was later appointed Physician-in-Ordinary to Edward VIII and subsequently became head of the medical advisers to George VI and Queen Mary.¹⁸⁸ Dawson was the first medical consultant to receive a peerage whilst being engaged in full-time practice.¹⁸⁹

Harley Street continued to be associated with the Royal family and their households.¹⁹⁰ Reginald Ernest Bickerton, ophthalmic surgeon, was appointed honorary surgeon to King George V from 1927 to 1932 and Richard Robert Cruise was Surgeon Oculist to King George V and Queen

¹⁸⁷ Anon, 'Sir William MacCormac', *Lancet*, Dec. 7, 1901, p. 1618.

¹⁸⁸ Anon, 'Viscount Dawson of Penn', *BMJ*, March 17, 1945, p. 389

¹⁸⁹ *Munk's Roll*, Vol. 1903, p. 448

¹⁹⁰ In 1946, Sir Arnold Walmsey Stott who specialised in diseases of the chest, was appointed Extra physician to HM Household, see *Munk's Roll*, Vol. V., p. 402. Some such as Edward Farquhar Buzzard were physicians to the King George V following their departure from Harley Street. Buzzard was physician-in-ordinary to George V from 1932-6, *Munk's Roll*, Vol. IV, (London, 1906), p. 473. Others included Louis Knuthsen who had a special interest in diseases of the skin. He was Physician-in-Ordinary to The Princess Royal from 1935 and from 1951 Extra Physician. *Who Was Who*, (London, 1987), p. 628.

Mary.¹⁹¹ Wilfred Trotter became Sargeant Surgeon to George VI, whilst Sir Morton Smart was his manipulative surgeon.

Social Life

The social life of the group or their interests outside medicine was difficult to determine as obituaries seldom provided this information nor was it included in the *Medical Directory*. Autobiographies, biographies and archival material suggest, however, that in common with Victorian genteel society, many Harley Street medical practitioners entertained at home.¹⁹² When John Langdon Down moved from his rented consulting rooms in Welbeck Street to his newly leased premises in Harley Street, he and his family became involved in many social events in London and “they attended social occasions in Harley Street [and] Fitzroy Street”.¹⁹³

George Harley was “a great diner-out, as well as a giver of diners”, which will not have helped the gout that plagued him during his early adolescence. In addition to frequent evening parties, Harley held a regular Sunday morning breakfast at his home, and invited his medical neighbours such as Sir Richard Quain. Other guests included the renowned novelist Charles Dickens, the celebrated artist George Cruickshank, the *Punch* Cartoonist John Leech, the naturalist Frank Buckland and Lord Lyon

¹⁹¹ *The Medical Who's Who*, (London, 1925), p. 143.

¹⁹² Examples include the ophthalmologist Walter Hamilton Jessop who invited distinguished members of the profession and in particular, ophthalmologists from around Europe to his house in Harley Street, which was once owned by Mr. Gladstone, see Anon, Walter Hamilton Jessop, *Lancet*, Feb. 24, 1917, p. 312. Others included the surgeon William Rose who was described as an “admirable dinner-giver” and excellent host, Anon, ‘William Rose’, *Lancet*, June 11, 1910, p. 1657.

¹⁹³ Ward, *Eponymists in Medicine*, p. 121.

Playfair, Vice-President of the Privy Council.¹⁹⁴ These “cannibal breakfasts” contained gastronomic delicacies from around the globe such as one-thousand-years-old Chinese eggs, sea-slugs, rats, mice, elephant feet, hedgehogs and Kangaroo tails.¹⁹⁵

Whilst a few medical practitioners had little time for activities that were not related to their profession, such as Guthrie Rankin whose “work was his hobby” and Mervyn H. Gordon, whose “work was everything to him”, many had wide-ranging interests and a number were members of London Gentlemen’s clubs.¹⁹⁶ For example, Bryan Donkin, was “particularly fond of the Savile club”. Several of the cohort, such as Walter Hamilton Hylton Jessop, collected pictures or rare books. Jessop invested in a number of Whistler lithographs, which had been exhibited at the Royal Academy. Like many of the group, Jessop enjoyed music, literature and country pursuits.¹⁹⁷ Fishing, shooting and to a lesser extent horse riding and bird watching, were popular outdoor activities for the group, as was gardening and playing golf. Of the more cerebral hobbies, music, literature and painting were favoured. Enjoyment of foreign travel was also frequently mentioned in the cohort’s obituaries.

The Image of the Harley Street Consultant

During the Victorian and Edwardian period the sartorial appearance of the medical practitioner and how he presented himself was a hallmark of his

¹⁹⁴ Tweedie, *Harley*, pp. 218, 309 and 335.

¹⁹⁵ *Ibid.*, pp. 218–225.

¹⁹⁶ Anon, ‘Guthrie Rankin’, *BMJ*, Sept. 27, 1919, p. 429 and Mervyn H. Gordon, *BMJ*, Aug. 8, 1953, p. 343.

¹⁹⁷ Anon, ‘Jessop’, *Lancet*, p. 312.

success. By the middle of the nineteenth century, the new dress code for distinguished medical practitioners and consultants consisted of trousers, frock coat and waistcoat worn with a fob watch, which replaced the breeches and tailcoat coat of the previous era.¹⁹⁸ During the first decade of the twentieth century,

Harley Street's high noon, [could be regarded as] the golden age of consulting practice ... when white spats were the insignia of medical eminence where formerly it was the gold-knobbed cane with the concealed pomander of sweet-smelling herbs; when frock coats and silk hats were the 'livery of the laborious week'.¹⁹⁹

Illustrations of the medical men, including those in Harley Street changed from the mid-nineteenth century to the start of the Great War. In the 1840s, portraits were reflective as demonstrated by the illustrations of Sir James McGrigor (Plate 2.6) and Sir Charles Mansfield Clarke (Plate 2.7).²⁰⁰ These were "representations of medical men, phenotypically and physiognomically rather as the profession might have wished itself to be seen, if pompous in its postures".²⁰¹ By 1914 cartoons, such as those of Sir William Jenner by Sir L. Ward (*Spy*), (Plate 2.8), were being published.²⁰²

A couple of years before he arrived in Harley Street, Thomas Jeeves Horder (later Lord) was described as wearing, "a long frock-coat and curly

¹⁹⁸ Penelope J. Corfield, *Power and the Professions in Britain: 1700-1850* (London, 1995), p. 140.

¹⁹⁹ Pound, *Harley Street*, p. 24.

²⁰⁰ Sir James McGrigor, Mezzotint by W. Ward after J. Jackson, in R. Burgess, *Portraits of Doctors & Scientists in the Wellcome Institute*, 1973, no. 1845.1 and Sir Charles Mansfield Clarke, Mezzotint by T. Hodgetts, 1833, after S. Lane, 1832, in R. Burgess, *Portraits of Doctors & Scientists in the Wellcome Institute*, 1973, no. 616.1.

²⁰¹ Roy Porter, *Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900*, (London, 2001), p. 268.

²⁰² Sir William Jenner, Colour Lithograph by Sir L. Ward [*Spy*], 1973, in R. Burgess, *Portraits of Doctors & Scientists in the Wellcome Institute*, 1973, no. 1529.4.

brimmed 'topper', which the dignity of his position imposed".²⁰³ Remembering his own career, David Ferrier, a neurologist registered in Cavendish Square reflected that in the 1890s, "which were supposed to be frivolous days which are now spoken of as the naughty nineties – all HPs [house-physicians] wore frock-coats on their rounds, and so did the HSs [house-surgeons]". By the beginning of the twentieth century, resident staff of a hospital, "always wore, when on duty, a white washable coat generally knee-length".²⁰⁴

There were a few men such as the (non-Harley Street) surgeon Tommy Annandale, Stewart's professor of clinical surgery at the Royal Edinburgh Infirmary, who clung to the "blood encrusted chocolate frock coat", which had hitherto been the norm.²⁰⁵ Ferrier maintained that the crisp and clinical white coat was introduced after the Boer War.²⁰⁶ The Harley Street ophthalmologist George Lawson, surgeon to the Middlesex Hospital for 33 years from 1856, was one of the first surgeons to replace the blood stained frock coat with a washable overall, though according to his obituarist this novelty was the subject of "not a little banter".²⁰⁷ It was not until the motorcar replaced the hansom cab from the late 1890's and the onset of the Great War, that the professional silk top hat worn by Harley Street consultants became outmoded.

²⁰³ Anon, 'Lord Horder of Ashford', *BMJ*, Aug 27, 1955, p. 565.

²⁰⁴ Phillis Cunnington & Catherine Lucas, *Occupational Costume in England, From the Eleventh Century to 1914*, (London, 1967), p. 309.

²⁰⁵ *Ibid.*

²⁰⁶ The first Boer War occurred in 1880-1881 but the main war lasted from October 1899 to May 1901. Quote from Anon, 'John Charlton Briscoe', *Lancet*, Mar. 5, 1960, p.554.

²⁰⁷ Anon, 'George Lawson', *BMJ*, Oct. 17, 1903, p. 1019.

The Harley Street urologist, Cyril Arthur Rankin Nitch, was typical of his generation in considering the correct attire for the consultant in the wards to be a morning coat and striped trousers.²⁰⁸ Reginald Pound discussed the “vanity” in Harley Street during the Edwardian period, when medical practitioners could be found attending their patients in “white spats, astrakhan collars, [and] carnation buttonholes”.²⁰⁹ Hunter Finlay Tod, senior aural surgeon at the London Hospital, took his sartorial elegance seriously. He was described as smartly attired and was “certainly pleased at being considered the best dressed man on the ‘London’ staff”.²¹⁰

Dr. Nathaniel Edward Yorke-Davies, an expert on dietetics, arrived in Harley Street in 1895. As with a small number of his fellow consultants, his patients came from all sections of society, from Royalty downwards. His slightly unorthodox approach to treatment included champagne for the consumptive. In the image on Plate 2.9, he wears the uniform of the consultant: the frock coat, the striped trousers, the waistcoat, the wing collar and spats.²¹¹ Though on this occasion he has left behind his silk top hat and instrument case.

Sir George Lenthal Cheate surgeon at King's College Hospital, who was described as the epitome of “Victorian sartorial perfection”, appeared as “one of the last survivors of the age of elegance”: he was “always

²⁰⁸ Anon, ‘Cyril Arthur Rankin Nitch’, *Lancet*, Sep. 27, 1969, p.702.

²⁰⁹ Pound, *Harley Street*, p. 31.

²¹⁰ Anon, ‘Hunter Finlay Tod’, *Lancet*, Feb. 3, 1923, p. 257.

²¹¹ Spy, ‘Men of the Day, No. 788, Dr. Nathaniel Edward Yorke-Davies’, *Vanity Fair*, April, 12, 1900, (London, 1900).

immaculately dressed with top hat and morning coat".²¹² Even by the 1950s, he did not use the private car, which was the then common mode of transport for the Harley Street medical practitioner. Instead, he hired a 1920s cab. Cheatle remarked that he was "maintaining the dignity of Harley Street".²¹³ Moreover,

he carried this elegance even into the designing of the white coats he wore at outpatients and during his ward visits. He smoked cigarettes continually, using a long holder with a mechanical device for ridding itself of the unexpended portion of the cigarette.²¹⁴

Few Harley Street medical men ignored the custom to dress smartly. The laryngologist Charles Parker "refused to conform in such matters as dress with the conventionalities of the age and scorned any effort to pose as the successful consultant". Although he remained in Harley Street for ten years from 1901 to 1911, perhaps as a consequence of his indifference to dress codes, "his practice was never large".²¹⁵

Conclusion

Throughout the eighteenth century, London medical practitioners set up practise in the City, East London and Holborn. By the end of the century, Mayfair was becoming a more popular and fashionable area for physicians and surgeons. By 1845, neighbouring Cavendish Square and the streets surrounding it, were increasingly prestigious areas in which to live and work; such was the cachet of this West End district that in a matter of a few decades medical practitioners began to spill over into Harley Street.

²¹² Anon, 'Sir Lenthal Cheatle', *BMJ*, Jan 13, 1951, p. 95.

²¹³ *Ibid.*

²¹⁴ Anon, 'George Lenthal Cheatle', *Lancet*, Jan. 13, 1951, p. 116.

²¹⁵ Anon, 'Charles Parker', *Lancet*, Feb. 5, 1938, p. 351.

Eventually, Harley Street began to be regarded as the holy grail of the medical world, attracting some of the finest medical practitioners in Victorian London who aspired to live a life ensconced into the highest echelons of society.

The next four chapters analyse all of the practicing medical men and women who arrived in Harley Street between 1845 and 1914 by using a prosopographical methodological framework; these results are interwoven by a very extensive use of primary published and unpublished sources to provide a more complete and historically sensitive analysis of Harley Street than has hitherto been offered.

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CHAPTER 3

Medical Education

The medical education of the Harley Street group was coterminous with the restructuring of nineteenth century medical education, which resulted in the Apothecaries Act of 1815, the 1858 Medical Act and the 1886 Medical Amendment Act. The consequences of these Acts for the Harley Street cohort was reflected in the increasing accumulation of their medical qualifications from the 1860s onwards. As the history of medical education and the various routes to qualification from the mid-nineteenth to the early twentieth centuries has received considerable attention from historians, it will not be discussed in depth in this thesis.¹

This chapter analyses the academic calibre of the Harley Street cohort by evaluating the level of their qualifications and determining the extent to which the group's education was homogeneous. Indicators of educational pre-eminence such as scholarships, medals and prizes awarded to the cohort during their undergraduate and post-graduate years were examined. The relationship between the cohort's professional achievements and educational background was also assessed. A comparative analysis of Harley Street with the Harley Street Area and with Greater London was undertaken to determine if those from Harley Street had, indeed, been

¹ For a comprehensive study of medical education and the passing of the 1858 Medical Act, see Walter Rivington, *The Medical Profession*, (London, 1888), Charles Newman, *The Evolution of Medical Education in the Nineteenth Century*, (Oxford, 1957), M. Jeanne Peterson, *The Medical Profession*, (London, 1978) and Thomas Neville Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945*, (Oxford, 1995).

awarded a higher level of degree (MD and MS) or the top ranking fellowship of the Royal Colleges or both.

Some historians have argued that the division in the medical profession between the general practitioner and the consultant élite was pivotal to the development of medicine throughout the 19th century. Dorothy Watkins found, for example, that these divisions were “represented through the level, type and place of qualification”.² Before an analysis of the Harley Street group’s medical qualifications is presented, the methods by which one could qualify in medicine in Victorian and Edwardian Britain will be discussed.

The Medical Acts of 1858 and 1886

Although anyone could practice medicine in nineteenth century Britain, practitioners had to hold a registrable qualification in medicine or surgery awarded by one of the 22 British licensing bodies to be included in the *Medical Register*. Under the 1858 “Act to Regulate the Qualifications of Practitioners in Medicine and Surgery”, medical practitioners with a single qualification from an approved licensing body were eligible to have their names listed in the *Medical Register*.³ The 1886 Amendment Act redefined the minimum registerable qualification as a diploma or degree in medicine, surgery and midwifery from a medical corporation or university in the

² Dorothy E. Watkins, ‘The English Revolution in Social Medicine: 1889-1911’, (London University: Ph D Thesis, 1984), p. 58. Watkins quotes Ivan Waddington “General Practitioners and Consultants in Early 19th Century England: The Sociology of an Intra-Professional Conflict” in Woodward and Richards, (ed) *Health Care and Popular Medicine in 19th Century England*, (London, 1977) and Frank Honigsbaum, *Division in British Medicine*, (New York, 1979).

³ Rivington, *Medical Profession*, pp. 94-98.

United Kingdom recognised by the GMC, as being able to grant such qualifications. As a concession, those who were permitted to register before 1886 on the basis of a single qualification were still admitted to the register and foreign degrees obtained by examination prior to 25th June 1886 were acceptable. Thus, medical practitioners who registered before June 1887 practised according to their qualification whilst those who registered after this date were eligible to practice medicine, surgery and midwifery.⁴

The basic qualification needed to practise medicine changed across the nineteenth century, from LSA (1815-1858) to either the LSA or the MRCS or another single qualification (1858-1886). In 1884, the RCS and the RCP introduced the conjoint diploma MRCS/LRCP and the first examinations were held in January 1885. Thereafter, this diploma became the standard qualification for general practice in England. Thus, from 1886, combinations such as MRCS and LRCP or MRCS and LSA were popular.⁵

There were three routes to pursuing medical qualifications: first, through the conferment of a university degree; second, by examination of a single qualification, or by a double qualification in medicine and surgery and from 1886, a triple qualification in medicine, surgery and midwifery from the conjoint board of the Royal Colleges of Physicians and Surgeons in England, Scotland and Ireland. The third route was by a licence from the Society of Apothecaries in England or from the Apothecaries' Hall Dublin in Ireland. By the beginning of the First World War there were 22 Medical

⁴ W. Oliver Hodges, 'Abstract of the Principle Laws Affecting the Medical Profession' *Medical Directory*, Vol. 1914, pp. 10-11.

⁵ For an analysis of this change see Watkins, 'English Revolution in Social Medicine', pp. 56-57.

Schools in England and Wales offering medical courses in preparation for the above examinations, 12 of which were in London. Though not all provided instruction in the full medical course of preliminary, intermediate and final or clinical exams.⁶

The basic university medical degree was an MB (physic) or the BS or BCh. (surgery). The higher qualification for physicians was the MD and for surgeons it was the ChM or MS. The standard, however, was not uniform: until 1897 St. Andrews University, for example, automatically awarded the MD to medical practitioners who were over 40 years of age (and it was not until 1907 that the first postgraduate qualified MD by thesis).⁷ Similarly, the MD could be bought from Aberdeen University upon the basis of written testimonials and several years in practice.⁸ The MS in Scotland could be acquired by those holding a Scottish medical degree and on the payment of a fee.⁹ There was no MB course at St Andrews until 1859, whereas the Royal University of Ireland medical students proceeded straight to the MD.

The second route to acquiring a registerable qualification was by a licence in medicine or surgery or in both, awarded by the medical and surgical Corporations. The Royal Colleges of Physicians and Surgeons in England, Edinburgh, Ireland and the Faculty of Physicians of Glasgow offered the higher qualification of member and Fellow. Fellows of the Royal

⁶ Sir George Newman, *Some Notes on Medical Education in England, A Memorandum Addressed to the President of the Board*, (London, 1918), pp. 1 and 5.

⁷ John S.G. Blair, *History of Medicine in the University of St Andrews*, (Edinburgh, 1987), pp. 155 and 171.

⁸ R. S. Downie and Bruce Charlton, eds., *The Making of a Doctor, Medical Education in Theory and Practice*, (Oxford, 1992), p. 11.

⁹ Rivington, *Medical Profession*, pp. 259-261.

Colleges were regarded as the élite, as they were an integral part of the governing body of the Colleges and had a right to vote in the elections for the members of the Council. Fellowships were usually awarded by examination at the RCSs and by election at the RCPs.¹⁰ From the time of their foundation, the Colleges were almost exclusively examining fraternities rather than teaching bodies.¹¹

The third examining body was the Society of Apothecaries in England or the Apothecaries' Hall Dublin. By the provisions of the Apothecaries Act 1815, apprentices who had served five years and who then passed the society's examination were granted a Licence: the LSA. In 1861, the society introduced a compulsory examination in mathematics and the classics following recommendations by the GMC.¹² A proposal to establish a conjoint board with the Royal Colleges in 1871 failed, due to the restriction imposed on the society by the 1815 Act. Once the Royal Colleges proceeded to establish their own conjoint board, the Society of Apothecaries was marginalized. To satisfy the requirements of the 1886 Amendment Act the Society applied to hold examinations in surgery, in addition to the existing examinations in medicine and midwifery.

The Society also learned that it would not be entitled to a position on the reformed GMC following the 1886 Act. As Penelope Hunting has shown

¹⁰ The laws relating to the fellowship of the RCS in Ireland were changed in the 1880s. Fellows had been elected by ballot, hereafter entry was by examination. The FPS Glasgow admitted two candidates by ballot the rest were by examination. For details of these see, Rivington, *Medical Profession*, pp. 238-252 and 563, 569.

¹¹ Downie and Charlton, *Making of a Doctor*, p. 11.

¹² Penelope Hunting, *A History of the Society of Apothecaries*, (London, 1998), pp. 206-207.

the Society struggled in the 1880s to preserve its position as an independent licensing body. It was only due to the appointment of examiners in surgery, a petition by the licentiates and the “forceful representation” by the Harley Street surgeon and the Society’s representative on the GMC, Robert Brudenell Carter, that the Society maintained its position on the GMC and its application to hold examinations in surgery was successful.¹³

Qualifications of the Harley Street Group

An analysis of the Harley Street cohort was undertaken to establish the proportion who were awarded a degree or a licence and to determine the level of their qualification from the respective awarding body. The results are shown in Table 3.1, Appendix C. Only earned degrees have been included in this Table. Though honorary degrees do not form part of the prosopography, they are discussed later in this chapter, as they were an important indicator of esteem within the profession.

The data used in Table, 3.1, Appendix C, were taken from the *Medical Directory* and crosschecked with information from the *Medical Register* and sources such as obituaries. All 657 male medical practitioners who were registered in Harley Street between 1845 and 1914 were included in the analysis. The qualifications of the cohort who arrived in the Street during the period were examined together with those who earned their degrees during their years of practice there, which for some, extended beyond 1914.

¹³ Hunting, *Apothecaries*, pp. 214 - 227. See also, Anon, ‘Robert Brudenell Carter’, *Lancet*, Nov. 2, 1918, p.607.

Table 3.2, Appendix C provides complete details of medical and other degrees held by the entire cohort.

Examinations for degrees such as the MB and MD became increasingly important in the Victorian era. The “magic letters” MD were an especially significant indicator of professional status for the British public who, according to Walter Rivington, were “happily ignorant of the varying standards of universities and traffic in university degrees”.¹⁴ Findings from the data that formed the basis of Table 3.2, Appendix C, indicated that almost half, 289 (43.99 per cent) of Harley Street practitioners had one MD whilst eight had two MDs and James McGrigor had three.¹⁵

The proportion of the cohort whose highest medical degree was MB/BMs totalled 25.72 per cent ($n = 169$), whilst Arthur Edward Giles had two MBs (from the universities of Liverpool and London). Hence, the majority, or almost three quarters of the Harley Street practitioners (69.71%, $n = 458$) were qualified MB or MD. It was further established that the majority of Harley Street MDs and MBs were earned at London University, with the Scottish Universities being the second most popular. In 1881, the University of Glasgow, and soon after the Universities of Edinburgh and Aberdeen, made it compulsory for medical students to take up the MS together with the MB as the primary qualifying exam.¹⁶ The majority of the Harley Street group who qualified MS did so after this requirement was introduced: 78 per cent of those who qualified MS

¹⁴ Rivington, *Medical Profession*, p. 255.

¹⁵ Mc Grigor qualified MD from the Universities of London, Edinburgh and Aberdeen.

¹⁶ James Coutts, *A History of the University of Glasgow*, (Glasgow, 1909), pp. 573-574.

Edinburgh and 90 per cent of those who earned their MS from Glasgow arrived in Harley Street in the period from 1895 to 1914. Results from the data base revealed that the acquisition of degrees relative to the number of medical practitioners in Harley Street increased during the period 1845-1914, which follows the increasing popularity of tertiary education for medical students in the nineteenth century.

In his advice to young medical practitioners wishing to establish a private practice in the late 1880s, the physician Jukes De Styrap advised them to be conversant with general literature and added that, "good conversational powers not infrequently produce a greater impression of professional ability than is *de facto* possessed by the conversationalist in question".¹⁷ In discussing the optimum education for the medical profession in 1905, Thomas Clifford Allbutt, who advocated a university arts degree, remarked that:

it is freely said of the abler men in our laboratories that those who enter them with minds already expanded on other kinds of study, such as language and literature, bring to the sphere of scientific studies a ripper understanding, and draw from them larger immediate powers and a richer endowment for later life.¹⁸

Despite his support for this course of study, he argued that the attraction of a university degree lay too often in its marketability rather than its mental cultivation.¹⁹

Few medical practitioners, apart from the élite, took Arts degrees.²⁰ The majority of male medical practitioners in the Victorian period bypassed

¹⁷ Jukes De Styrap, *The Young Practitioner*, (London, 1889), p. 21.

¹⁸ Thomas Clifford Allbutt, *On Professional Education with Special Reference to Medicine*, (London, 1906), p. 37.

¹⁹ Allbutt, *Education*, p. 38-46.

a liberal education and attended medical school straight after their secondary education. Just over a fifth of the Harley Street cohort (21.46%, $n = 141$), however, had a liberal education, as indicated by the 95 practitioners who held an MA and the 46 who held a BA. This was the typical educational route for a physician. Almost a fifth of the cohort chose this route and were later elected FRCP.

For some universities such as London, Durham, Oxford, Cambridge and Trinity College, Dublin, a bachelor of arts degree was a prerequisite for medical study.²¹ From 1860 the Natural Science Tripos at Cambridge, which included the study of Chemistry, Physics and Biology, led to an Arts degree. Whilst the first set of tables in this chapter indicated the highest degree obtained by those in Harley Street, Table 3. 3 Appendix, C provides a breakdown of licences and the levels of these licences obtained from the Royal Colleges and the Societies of Apothecaries.

Table 3.3 Appendix C, shows that over half (51.14 per cent, $n = 336$) of all medical practitioners who were registered in Harley Street between 1845 and 1914 held the élite licences of fellowship of the Royal Colleges of Physicians or Surgeons of England, Scotland or Ireland during their time in the Street.²² Of these men, 14.76 per cent ($n = 97$) were FRCPs only, and an additional 17 men were FRCP *and* FRCS whilst, six individuals held two FRCPs; from London *and* either Ireland or Scotland. Of the surgeons in

²⁰ Peterson, *Medical Profession*, p. 58.

²¹ Charles Bell Keetley, edited by the author and Robert Wharry, *The Students and Junior Guide to the Medical Profession*, 2nd edition (London, 1885), pp.19, 52 and 59.

²² Hence, 340 individuals held 365 Fellowships.

Harley Street, 36.38% per cent ($n = 239$) were FRCSs only, a further 17 had both FRCP and FRCS, whilst two individuals, Henry MacNaughton Jones and Inglis Taylor held the FRCS from Edinburgh and London. Most of the cohort (79.60%, $n = 532$) were fellows or members of the RCP or RCS. After the 1886 Amendment Act the majority of general practitioners in Britain held the combined MRCS/LRCP as their highest qualification, whilst only a minority (7.31%, $n = 48$) of Harley Street men did so.

Of the 20.85 per cent ($n = 137$) who held the LSA, almost all of them had additional medical qualifications. Five qualified LSA only, two of these men, Charles Oswin and Park Pittar Lattey, gained their LSA in 1824 and 1840 respectively, before the development of the professionalisation of medicine from the middle of the nineteenth century.²³ Of the 57 who held the Licence in Midwifery (LM), they also held other medical qualifications, such as the LRCS or LRCP from the RCP or RCS in Scotland or Ireland. Although the 1886 Medical Amendment Act had made the triple qualification compulsory, most of those who qualified LM ($n = 37$) did so before this requirement was introduced.

A. M. Cooke noted that FRCPs constituted a very small section of the medical profession: as few as one per cent were listed in the *Medical Register* in 1851 and this remained unchanged for nearly a century.²⁴ He

²³ For a discussion of various models of professionalisation see J. B. Morrell, 'Professionalisation' in, R. C. Olby, G. N. Cantor, J. R. R. Christie and M. J. S. Hodge, eds., *Companion to the History of Modern Science*, (London, 1996), pp. 980-989 and Paul K. Underhill, 'Science, Professionalism and the Development of Medical Education in England: An Historical Sociology', (PhD, University of Edinburgh, 1987), *passim*.

²⁴ A. M. Cooke in *The History of the Royal College of Physicians of London*, Vol. 111, (Oxford, 1972), pp. 803-804.

further remarked that whilst the fellows wielded considerable power within the medical profession, the majority of the educated public would have been unfamiliar with the letters FRCP; whereas Fellows of the Royal Society or Royal physicians or surgeons would have been, for example, better known to the educated classes.²⁵

While all FRCPs held a university degree, over a third (37.50%, $n = 96$) of the 256 Harley Street practitioners who qualified FRCS (including the 17 who had both FRCP and FRCS) did not have a degree.²⁶ Most were FRCS (England) and four were FRCS (Edinburgh), whilst one was FRCS (Ireland).²⁷ Henry Hancock, for example, who had received his medical education at Westminster Hospital and joined the staff at Charing Cross Hospital in 1839, gained the FRCS in 1843 without having acquired a university degree. Candidates were eligible for the FRCS after six years of professional study, three of which had to be at a recognised London hospital. For those who held an Arts degree, however, the period of study was reduced by one year.

Qualifications: Harley Street, the Harley Street Area and Greater London in 1845.

Charles Singer and S.W.F. Holloway analysed all medical practitioners in the 1856 *Medical Directory* (just prior to the 1858 Medical Act). They

²⁵ Cooke, *RCP*, p. 804. In 1835, the Royal College of Physicians removed the restriction of awarding the FRCP to Oxbridge graduates only.

²⁶ Until 1835, Fellows of the RCP were obliged to hold a degree from an English university.

²⁷ An analysis of those who held the FRCS without a university education showed that there was no preponderance in any one year or decade; the individuals were spread throughout the period.

classified practitioners into eight categories and their analysis showed that 54.6 per cent qualified LSA/MRCS, 18.5 per cent were MRCS only, whilst 11.8 per cent were LSA only.²⁸ Singer and Holloway's study further showed that only 3.9 per cent qualified MD, MB, FRCP, LRCP or Extra-LRCP. Before 1815, 3.4 per cent had been in practice and the balance, 7.8 per cent held foreign, Scottish or Irish diplomas.²⁹ Digby found in her study of general practitioners in the period 1847-1856 that her proportions were comparable to Singer and Holloway's: according to her data 75 per cent of GPs had qualified LSA or MRCS or both and an additional 13 per cent qualified MB or MD.³⁰ In the first part of the nineteenth century few aspiring medical practitioners apart from those wishing to become pure physicians, attended university.³¹

The findings in Tables 3.4 and 3.5, Appendix C, for Harley Street, the Harley Street Area and Greater London show that in 1845 (as also shown in a similar study by Dorothy Watkins), the MRCS, LSA, or combined MRCS/LSA were the standard qualifications for the majority of medical practitioners in London.³² In contrast, the most commonly held qualifications in Harley Street were Fellowship of the RCS or the RCP (50 per cent) or MD (25 per cent). The Harley Street Area had comparable

²⁸ Charles Singer and S.W.F. Holloway, 'Early Medical Education in England in Relation to the Pre-History of London University', *Medical History*, Vol. 4, 1960, p. 4.

²⁹ *Ibid.*

³⁰ Anne Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford, 1999), p. 51, the graphs on pages 52 and 218 for GPs with MDs did not correspond with the text on page 51, therefore the figures in the text were taken as valid for the purpose of comparatives in this thesis.

³¹ *The Universities of the Nineteenth Century, Birth of Modern Britain Series*, Michael Sanderson, (ed.), (London, 1975), p. 80.

³² Watkins, 'The English Revolution in Social Medicine', p. 57.

results, the majority being Fellows (63.16 per cent) and almost a quarter, (21.05 per cent) qualified MD.

Rivington found that the majority of medical practitioners in London up to the mid-1880s graduated from Scottish universities. London was less popular, as in 1880 only 20 per cent of medical students in London were registered for the University of London's MB degree.³³ The Scottish system of medical education, typified by Edinburgh University, offered a broader curriculum than at Oxbridge to satisfy the requirements of the RCP for its Licentiate. The syllabus included surgery and midwifery and was thus geared towards general practice.³⁴ However, from the time of the 1858 Medical Act, the prominence of the Scottish universities began to decline, as there was "a hierarchy of respect among the institutions responsible for medical education and ... in particular, the major Scottish universities were failing to provide the highest standards of examination for prospective entrants to the profession".³⁵

Whilst over 77 per cent of the Greater London practitioners held an MRCS, LSA or a combination of these as their highest qualification, only 25 per cent of the Harley Street cohort held these qualifications. The majority, that is, 75 per cent of those in Harley Street and 84 per cent in the Harley Street Area, held the élite licences of FRCP or FRCS or the MD.

³³ Stella V. F. Butler, 'Science and the Education of Doctors in the Nineteenth Century', Ph. D, University of Manchester, December 1981, p. 194.

³⁴ Underhill, 'Science, Professionalism', pp. 94-95.

³⁵ James Bradley, Anne Crowther and Marguerite Dupree, 'Mobility and Selection in Scottish University Medical Education, 1858-1886, *Medical History*, Vol. 40, 1996, p. 1. These authors argued that Scottish universities were not selective in the medical students they accepted to their courses and Scottish university exams were less rigorous than in English universities.

Qualifications Obtained by the 1880 Group

As the number of medical practitioners registered in Harley Street, the Harley Street Area and Greater London was so small in 1845, it was necessary to explore whether the cohort in Harley Street continued to obtain the highest level of qualification in later years. Thus, the middle of the period, the year 1880, was examined.

The results from the analysis in Tables 3.6 and 3.7, Appendix C, showed that almost a third (29.82 per cent) of the Harley Street group held the FRCP. This represented 5.57 per cent of the total number of fellows ($n = 305$) at the Royal College of Physicians for the year 1880.³⁶ Almost the same percentage of FRCPs (29.16 per cent) practiced in the Harley Street Area as those who were in Harley Street, whilst only a small proportion (1.52 per cent) of medical practitioners in the Greater London were elected FRCP. Therefore, there were nearly 20 times as many FRCPs in Harley Street and the Harley Street Area than there were in Greater London. In total, more than half (56.14 per cent) of those registered in Harley Street in 1880 held the élite licences of FRCP or FRCS compared with a similar number for the Harley Street Area (51.67 per cent), but more than four times the percentage of Greater London (13.71 per cent).

The findings also show that over half of the medical practitioners in Harley Street in 1880 had qualified MD (54.39 per cent) in contrast to the Harley Street Area, which had just over a third (38 per cent) and in Greater London less than a quarter (22.84 per cent) qualified MD. Rivington's

³⁶ Cooke, *RCP*, p. 1131.

analysis of the *Medical Directory* for 1884 showed that almost a third (32.2 per cent) of medical practitioners in London, which would have included Harley Street, had qualified as an MB or MD.³⁷ Thus, if the proportion were roughly the same for 1880 as 1884 then Harley Street had over twice the number of medical graduates than Greater London.

A breakdown of the universities awarding the MD to the Harley Street cohort is provided in Table 3.7 Appendix C. This analysis of MDs from the sample in 1880 demonstrates that of those who earned an MD, almost half (42.42 per cent) were from the University of London — more than any other single university, and the same number qualified MD from London as did from the Scottish universities combined. Scottish Universities were the most popular for the Harley Street Area (29.17% of those who qualified MD). Of the Greater London medical practitioners, the majority (53.06%) earned their MD at a Scottish University and only a few qualified from London (12.24% of those who qualified MD).

Although London was the centre of medical education in the middle of the nineteenth century, it was not until 1834 that UCH was founded and two years later that the University of London (established in 1828) became an examining body for University and King's Colleges.³⁸ The established medical schools such as St. Bartholomew's resisted any change in that

³⁷ Rivington, *Medical Profession*, p. 261.

³⁸ Singer and Holloway, 'Medical Education', p. 1 and F.G. Brooks, 'The University of London', PhD, University of London, 1958), p.22, quoted in. Butler, "Science and the Education", p. 40.

direction fearing potential loss of income.³⁹ Students, therefore, were forced to obtain a recognised qualification, usually LSA/MRCS. In 1839, the University of London awarded its first medical degrees.⁴⁰

Various commentators have acknowledged the exacting standards of the University of London medical degree and the high number of failures relative to other British universities.⁴¹ Writing in the mid 1880s, Charles Bell Keetley argued that the University of London's prestige was due to its "difficult and searching examinations".⁴² Rivington observed that for the 5,219 men in England holding an MB or MD in 1884, only 622 graduated from the University of London.⁴³

In 1880, no medical practitioner in Harley Street or the Harley Street Area held only the most basic medical qualifications of the LSA or LM, whereas 6.09 per cent ($n = 12$) of Greater London medical practitioners did. The vast majority of medical practitioners in Greater London were general practitioners qualified either MRCS/LSA or MRCS/LRCP.⁴⁴

³⁹ Bonner, *Becoming a Physician*, p. 144.

⁴⁰ Cooke, *RCP*, p. 931

⁴¹ Bradley, 'Mobility', p. 21.

⁴² Keetley, *Medical Profession*, p.18.

⁴³ Rivington, *Medical Profession*, pp. 262-263.

⁴⁴ Singer and Holloway, 'Medical Education', p. 4 and p. 12., stated that general practitioner was becoming familiar term by the 1860s; however, they argued that the practice began earlier, following the Apothecaries Act 1815, which permitted LSAs to practice medicine and charge for this service. Hunting, in *Apothecaries*, pp. 196-197 and p. 287 fn. 7., argued that the term was first used by J. Bellers in *An Essay towards the Improvement of Physic* (1714) and adopted by R. M. Kerrison in *An Inquiry into the Present State of the Medical Profession in England* (1814). Hunting contended that from the 1830s the term was understood to mean a person holding the LSA and MRCS.

Qualifications Obtained by the 1914 Group

As the number of combinations of qualifications was so extensive for 1914, containing 191 different categories, the total has been included in Table 3.8, Appendix C. The university degree of MD was tabulated in Table 3.9 Appendix C. Thirty-one (11.15 per cent) of the medical practitioners in Harley Street in 1914 were FRCP, which represented almost 9 per cent (8.80 per cent) of the 352 fellows of the Royal College of Physicians of London and a further two individuals were FFPS.⁴⁵ Although the percentage of FRCPs had declined from 1880 to 1914, the proportion of physicians in Harley Street, nevertheless, accounted for almost double the proportion in the Royal College of Physicians in 1914 than they had in 1880. Almost half (48.92 %, $n = 138$) of all the medical practitioners registered in Harley Street in 1914 were Fellows of the Royal Colleges of Physicians or Surgeons. The percentage of Fellows in Harley Street Area had been roughly equivalent to Harley Street in 1880, but by 1914 had fallen considerably to 17.04 per cent ($n = 68$).

The number of Fellows in Greater London was dramatically lower than the Harley Street group, amounting to less than one per cent (0.06, $n = 7$). The difference is significant: it confirms that up to the onset of the Great War, Harley Street was the preferred address for élite medical practitioners in London. London teaching hospitals routinely required the higher qualifications of FRCP, FRCS, MD or MRCP for the positions of assistant-physician or assistant-surgeon, which was a stepping-stone to one of the

⁴⁵ Total number of Fellows from Cooke, *RCP*, p. 1132.

prestigious honorary appointments. Over four fifths (83.45%, $n = 232$) of the 1914 Harley Street group satisfied this criteria, with 21.58 per cent ($n = 60$) who qualified MD (but were not Fellows of the Royal Colleges) and a further 12.23 per cent ($n = 34$) were MRCP. Comparable figures for the Harley Street Area were just over three fifths (63.16%, $n = 252$) satisfying the above criteria, with 45.61 per cent qualified MD ($n = 182$) and 0.50 ($n = 2$) MRCP. How did these figures compare to the Greater London Area? Significantly fewer; just over a quarter (25.76%, $n = 85$) satisfied the requirement for a junior post at a London teaching hospital.

Student Prizes and Awards

One of the criteria employed in determining the academic calibre of the cohort was the accumulation of the prizes, awards, exhibitions or scholarships that they received during their medical education or training.⁴⁶ Archives of the relevant universities, hospitals and the Royal Colleges were consulted to examine these prize winners. Few of these universities contained straightforward lists of prizes and prize winners in medicine, with the exception of Cambridge and Oxford Universities.⁴⁷ The most useful sources listing university prizes were the calendars or handbooks published typically annually, which contained details of the bursaries together with the prize winners. The hospital archives revealed similar details in

⁴⁶ These were listed in the *Medical Directory*, however, the awarding institution was not always identified, and investigation of other sources was necessary.

⁴⁷ See J. R. Tanner, (ed.) *The Historical Register of the University of Cambridge, to 1910* (Cambridge, 1917), thereafter *Historical Register Supplements*, published every ten years to 1990 and the, Oxford Historical Register, 1220-1900.

calendars or handbooks (for example, in Bart's) or the prospectuses or minute books for the period (for example, in St Mary's).⁴⁸

Very little attention has been paid by historians to the role of prizes and awards given to medical students; few secondary sources listed the prizes and the prize winners by year. H. Willoughby Lyle's, *King's and Some King's Men*, was an exception, although it did not provide details of the monetary value of each prize.⁴⁹ Indeed, Jeanne Peterson was one of the few historians who discussed the importance of prizes or scholarships in the field of medicine in general.⁵⁰ Nonetheless, accounts of the benefactors and an analysis of the award system is provided in Penelope Hunting's recent *History of the Society of Apothecaries*, and Mark Weatherall's *Gentlemen, Scientists and Doctors: Medicine at Cambridge, 1880-1940*, and recent histories of Bart's and St Mary's, provide useful references for individual institutions.⁵¹

⁴⁸ The Calendars for the University of St Andrew's, for example, were according to the keeper of manuscripts Dr Norman Reid, sporadic up to 1914 and of limited content before c.1880. The first Handbook for Bart's was published in 1841.

⁴⁹ H. Willoughby Lyle, *King's and Some King's Men*, (London, 1935) and see Rivington, *Medical Profession*, pp. 710-721 for the value of scholarships and prizes by medical school in 1885-1886.

⁵⁰ Peterson, *Medical Profession*, pp. 75-85. Rivington, *Medical Profession*, pp. 534-723 provides details of some of the cash prizes but offers little commentary on their importance. Histories of Hospitals and Medical Colleges such as W. R. Merrington, *University College Hospital and its Medical School: a History*, (London, 1976) and V.C. Medvei and J.L. Thornton's, *The Royal Hospital of Saint Bartholomew*, (London, 1874) contain scant, and in some cases no references to the system of cash prizes and scholarships.

⁵¹ Hunting, *Apothecaries*, pp. 248-253, Mark Weatherall, "Gentlemen, Scientists and Doctors: Medicine at Cambridge, 1800-1940", *History of the University of Cambridge, Texts and Studies 3*, (Cambridge, 2000), pp. 248-53. Keir Waddington, *Medical Education at St Bartholomew's Hospital, 1123-1995*, (Suffolk, 2003). E. A. Heaman, *St Mary's, the History of a London Teaching Hospital*, (London, 2003), pp. 43 and 63. Others include Willoughby Lyle, *King's*, Appendix X, pp. 509-540.

By the end of the nineteenth century, Peterson argued, "competitions had become a major part of student life".⁵² She also suggested that together with the expansion of medical societies and the publication of medical textbooks and journals, the prize-system in medical colleges was a forum "for the exhibition of medical and scientific achievement".⁵³ The prize winners who gained the attention of their medical staff increased their chances of a successful application for a position within the hospital or college. Journals such as the *BMJ*, the *Lancet* and hospital reports also published the names of the award winners and the monetary value of the prize, and "like the recommendation of one's master, the medical school prize served as an institution's endorsement of the new medical man".⁵⁴

The amount of possible prizes for medical students from 1845 to 1914 was extensive, but the frequency, requirements and monetary value of the prizes or scholarships varied according to the awarding body.⁵⁵ By the end of the nineteenth century, the competition between the medical schools to attract medical students had intensified and the increased value of scholarships, were an indication of this.⁵⁶ At this time Merton College, Oxford offered 18 scholarships, whilst Balliol awarded eight and Christ Church offered one.⁵⁷ The teaching hospitals such as Bart's typically

⁵² Peterson, *Medical Profession*, p. 83.

⁵³ *Ibid.*, p. 172.

⁵⁴ *Ibid.*, pp. 83-84.

⁵⁵ At Durham University, for example, the University medical scholarships of £25 p. a from 1856 were tenable for 4 years, the Pears scholarship, founded in 1898 was awarded triennially and tenable for three years with a value of £40 p.a. Durham University Calendar, 1930-31, pp. 571-572.

⁵⁶ Rivington, *Medical Profession*, pp. 710-721.

⁵⁷ Rivington, *Medical Profession*, pp. 589-590 and 710-722.

awarded prizes at entrance (five in 1914), at the end of the first years (five in 1914), at the end of the second year (five in 1914, including the Foster, Harvey and Wix prizes) and at the end of the third and later years (11 in 1914, including scholarships in medicine and surgery such as the Brackenbury). The total value of prizes at Bart's amounted to approximately £930 per annum by 1917.⁵⁸

At the London Hospital in 1899-1900, seven different types of entrance scholarship were awarded, ranging from the Price scholarship for science with a value of £120 to the Buxton scholarships, worth £30 and £20.⁵⁹ In addition, 21 prizes were awarded to existing students, which included prizes in practical anatomy of £4 and £6 and the triennial Hutchinson Prize of £35 for an essay on clinical surgery. Gold medals in medicine and surgery, were awarded on an annual basis (in 1858, the first prize-winner in medicine was Morell Mackenzie). There were hospital, obstetric midwifery and osteological scholarships; the Duckworth Nelson and the Letherby prizes (junior and senior) ranged in value from £10 to £20.⁶⁰

Charles Bell Keetley maintained that prizes and scholarships had an importance that exceeded their intrinsic value. He argued in 1885 that, "a gold medal worth £5 has, before now, led to an income of a thousand a-

⁵⁸ Anon., *Saint Bartholomew's Hospital Reports*, 1917 and 1918, Vol. LIII, (London, 1920), pp. 55-57. For details of the value of scholarships and prizes awarded by the British medical schools see Rivington, *Medical Profession*, p. 722.

⁵⁹ The Royal London Hospital Archives, Prospectus 1899-1900, pp. 27-87. There was also a Price scholarship for physiology, value £60.

⁶⁰ The osteological scholarship founded in 1865 was discontinued in 1871.

year”.⁶¹ Keetley’s figure was enough, therefore, to satisfy the *BMJ*’s calculation that by 1901 at least £700 was essential to maintain a gentlemanly way of life.⁶² Prizes and scholarships could also be of significant monetary value in themselves. Vincent Warren Low, for example, helped to defray the cost of his education by winning several exhibitions whilst at Cranleigh School, and in 1885, he was awarded the science entrance scholarship at St Mary’s Medical School.⁶³ The cost of medical education could deter some students from medicine, and the provision of cash prizes changed the career path of such individuals as Walter Hamilton Hylton Jessop. Whilst Jessop was at Cheltenham College his father died and Jessop was subsequently sent to the modern school in Bedford. After completing his schooling, he embarked on a career in the Indian Civil Service. It was only when he won the Tancred scholarship at Caius College, Cambridge in 1871 that he had sufficient funds to study medicine at the College.⁶⁴

Entrance scholarships and other prizes could cover a significant portion of the student’s fees. Keetley estimated the total cost of medical education for a London student to be £600 in 1885, whilst Peterson estimated the average cost to have been between £533 and £581 in 1884.⁶⁵ Rivington’s calculation in the late 1880s, of between £100 to £140 per annum for four years would, therefore, appear to be the average.⁶⁶ Although

⁶¹ Keetley, *Medical Profession*, p. 28.

⁶² Anon, *BMJ*, Vol. I, 1901, pp. 513-14 quoted in Digby, *General Practice*, p. 41.

⁶³ Zachary Cope, *The History of St. Mary’s Hospital and Medical School, or A Century of Medical Education*, (London, 1954), pp. 181-82.

⁶⁴ Anon., ‘Walter Hamilton Hylton Jessop’, *Lancet*, Feb. 24, 1917, p. 310.

⁶⁵ Figures quoted in, Bradley, ‘*Mobility*’, p. 19. See also Peterson, *Medical Profession*, p. 74

⁶⁶ Rivington, *Medical Profession*, p. 694.

there was the additional cost of materials and books plus living expenses of approximately £100 p.a. for four to five years to be considered.⁶⁷ Keetley calculated that about half of the cost of residence at Oxford University could be covered by scholarships.⁶⁸ Other awarding bodies such as the Society of Apothecaries, offered both a medical scholarship and a surgical scholarship of £100 p.a. each for two years.⁶⁹ In addition to some prizes being a good source of funds, they were also a very important indicator of academic ability in an increasingly professionalized market:

as the London hospital medical schools expanded the numbers of courses available to students ... relied on both efficiency in practice and the ability to teach. Students with these abilities were singled out in their careers by success in scholarship and prize examinations.⁷⁰

In his 'Hints to Students', William Tennant Gairdner, physician to the Royal Infirmary of Edinburgh, condemned the self-seeking attitudes developing amongst students, whom he felt had a duty to perform to society, which should be one of self-sacrifice and devotion:

I have seen some of the very ablest of our students display, in the mere struggle for college prizes, all the evidences of a selfish and unscrupulous nature.⁷¹

However, this ambition perhaps, unsurprisingly, led many of the prize winners such as William Watson Cheyne to have distinguished medical careers.⁷² Cheyne studied medicine at Edinburgh University and

⁶⁷ *Ibid.*

⁶⁸ Keetley, *Medical Profession*, p. 58.

⁶⁹ Rivington, *Medical Profession*, p. 534. These were later made "redundant by the provisions of the 1886 Medical Act". See Hunting, *Apothecaries*, p. 249.

⁷⁰ Weatherall, 'Medicine at Cambridge', p. 113.

⁷¹ William Tennant Gairdner, 'Hints to Students, on the Prosecution of their Studies: being Extracts from the Introductory Address at Surgeon's Hall, Session 1856-7', *Edinburgh Medical Journal*, Vol. III, No. 4, Oct. 1857, p. 351

⁷² There are many examples of prizewinners who developed successful or distinguished careers and they included the urologist Peter Freyer (gold Medal MD from RUI).

graduated MB and CM in 1878. During his residence at Edinburgh, he gained twelve medals, including three for anatomy, physiology and chemistry. Cheyne went on to develop a distinguished career in surgical science: he won the Jacksonian prize (1880) for his dissertation on antiseptic surgery and was elected FRS (1894), Hunterian Orator (1915) and President of the RCS (1914-1917).⁷³ Cheyne is best known for his bacteriological research in which he confirmed and promoted Lister's theory of antisepsis. In 1924, he was awarded the Lister Memorial Medal by the RCS in recognition of distinguished surgical science.

The majority of the prize winners also taught at the university or hospital in which they were awarded a prize.⁷⁴ As a student, Arnold Lawson (later Sir) was awarded the senior entrance scholarship at the Middlesex Hospital in 1886 (worth £100) and the Broderip scholarship in medicine, surgery and pathology (worth £60). He went on to win the Hetley Clinical prize in clinical medicine, surgery and gynaecology (worth £25), and he later became senior surgeon to the Ophthalmic Department at the Middlesex Hospital.⁷⁵

Medical schools were aware of the attraction of these rewards for academic success. In the late 1880s, St George's provided £857 per annum

⁷³ Anon, 'Sir William Watson Cheyne', *BMJ*, 30 Aug. 1932, pp. 821-22.

⁷⁴ Lyle, *King's*, pp. 393-396 and 413-414. There are many examples of this at King's College alone and they include Sir Raymond Payne Crawford, Warneford scholar (1889), junior scholar (1891) and senior scholar (1894) at King's College London who later became consulting physician to King's (1930) and Emeritus Lecturer on Medicine in the Medical School. For additional King's prizewinners see above.

⁷⁵ H. Campbell Thomson, *The Story of the Middlesex Hospital Medical School*, (London, 1935), p. 129. Other Middlesex prize-winners included Walter Knowsley Sibley and Joseph Strickland Goodall. Goodall was a senior entrance scholar later became Sub-Dean of the Hospital.

for scholarships and prizes (including, £380 p.a. for entrance scholarships) and Bart's awarded £692 per annum (including, £310 p.a. for entrance scholarships).⁷⁶ Increasing competition between the medical schools in the second half of the nineteenth century forced them to maintain a prize system. Guy's Hospital, which refused to offer entrance scholarships and prizes from 1847 to 1859, experienced a decrease in the number of applications to study medicine. When the Treasurer, Mr. Turner, reversed this policy in 1859 and introduced a meritocratic system, the effect was that, "prizes and numerous successes in the examination for the MB of London have combined to produce a very large entry of first-year students".⁷⁷ From the 1840s to the 1890s, the surgeon G. M. Humphry pressed for improvements in the medical education at Cambridge University. He endeavoured to attract high calibre of medical students by sending a list of available prizes and scholarships to the medical press. Although there were no specific prizes for medical students, entrance scholarships for natural science, which were open to them, were instituted in a number of the colleges at Cambridge from the 1860s.⁷⁸

Nearly a third ($n = 209$) of Harley Street medical practitioners were awarded prizes, scholarships (entrance scholarships and those open to existing students), or exhibitions from Universities during their degree course or from hospitals or Royal Colleges during their medical training. To determine whether the Harley Street cohort received more awards than

⁷⁶ Rivington, *Medical Profession*, pp. 710 – 722.

⁷⁷ Hector Charles Cameron, *Mr Guy's Hospital*, (London, 1954), pp. 227-28.

⁷⁸ For details see Weatherall, *Medicine at Cambridge*, pp. 113-15.

other medical practitioners in the Harley Street Area or Greater London, the samples in Table 3.10 Appendix C, were assessed for the years 1845, 1880 and 1914.

As has been mentioned previously, the style of the *Medical Directory* changed throughout the period covered by this thesis. Thus, none of the medical practitioners examined listed their prizes in the 1845 *Medical Directory*. The findings showed that awards earned during students's graduate and undergraduate years had become increasingly important with more prize winners over the period. The results also demonstrated that in 1914 Harley Street practitioners were awarded more than ten times as many of these awards as medical practitioners in other parts of London. Thus, another criterion for the Harley Street group as an intellectual élite has been fulfilled.

Medical Training

By 1914, there were eleven medical schools in London, in which a medical student could take the preliminary, intermediate and final subjects.⁷⁹ Since 1905, Westminster Hospital and later St. George's Hospital examined only the final examination and students took their preliminary and intermediate examinations at King's College.⁸⁰ In common with the majority of medical practitioners in Victorian and Edwardian Britain, the Harley Street group pursued their medical training at a university or a hospital. Practical apprenticeship, a method of medical training whereby a student paid a

⁷⁹ This included the LSMW.

⁸⁰ S. Squire Sprigge, *Some Considerations of Medical Education* (London, 1910), p. 64.

qualified medical practitioner to teach him became less popular from the 1850s and it was not a common method of medical training for the Harley Street cohort.⁸¹ Digby noted the demise of the apprenticeship system over the course of the nineteenth century before it was finally abolished by the GMC in 1892.⁸²

Table 3.11 Appendix C examines the place of training for the Harley Street group. By 1914, in addition to those in London there were nine medical schools in the provinces, eight in Scotland and eight in Ireland. Hospitals or universities with less than five students from the cohort have not been included in Table 3.11 Appendix C, as they were too numerous. The figures below are also not mutually exclusive; almost half (49.41 per cent, $n = 294$) of those who recorded their place of medical training in the *Medical Directory* trained at more than one medical school or university. Reginald Ernest Bickerton, for example, received his medical training at the London Hospital and the universities of Berlin and Vienna, whilst John Frederick Smith trained at the London Hospital and the Universities of Halle, Leipzig and Oxford. Ascertaining the medical school awarding the cohort's degree was problematical; as many medical practitioners listed medical schools *attended* not simply the awarding institution. In addition, the years in which they attended the medical school were not returned to the *Directory*.

⁸¹ Digby, *General Practice*, p. 53.

⁸² *Ibid.*, pp. 43-44 and 47.

Almost four fifths of the cohort (79.69 per cent, $n = 517$) received their training at one of the large London teaching hospitals (36 received their training at more than one of these hospitals, so they were deducted from the total of 553). Beginning in 1861, attendance at medical schools began to be recorded in the *Medical Directory*. Of the 62 medical practitioners who did not include details of their Medical School in the *Directory*, 33 were in Harley Street and listed in the *Directory* before 1861.⁸³ Thus, it is possible that the number who received their training at the metropolitan hospitals included some of those who did not return these details to the *Directory*. George Busk, for example, who arrived in Harley Street in 1856, received his medical training at St Thomas's and St Bartholomew's, but he did not return these details to the 1856 *Medical Directory*.⁸⁴

The results in Table 3.11 Appendix C, show that Bart's and UCH were the most popular choice of medical schools for the cohort. Waddington found that between 1788 and 1939, an increasing number of medical students were Bart's men, whilst Rivington found that Bart's had the highest number of registered medical students in the late 1880s.⁸⁵ Rivington's analysis of the number of students registered at medical schools in London in 1885 and 1886 showed that Thomas's had the second highest intake followed by London, Guy's, UCH, King's St Mary's, Charing Cross,

⁸³ The medical training of 61 could not be ascertained. Half of those who did not provide these details arrived in Harley Street before 1860, the rest were spread fairly evenly through out the period 1860 to 1912

⁸⁴ George Busk's details were found in Gordon Cook, "George Busk FRS, (1807-1886), Nineteenth Century Polymath: Surgeon, Parasitologist, Zoologist and Palaeontologist", *Journal of Medical Biography*, Vol. 5, 2, (May 1997), pp. 88-101.

⁸⁵ Waddington, *Bart's*, pp. 219-221 and Rivington, *Medical Profession*, pp. 677-678.

St. George's, Westminster and finally the Middlesex.⁸⁶ By the 1890s, however, whilst Bart's retained its position as the largest London medical school, Guy's had the second highest intake followed by St. Mary's.⁸⁷ Tables 3.12 and 3.13 Appendix C, show the medical schools attended by medical practitioners who were in Harley Street, the Harley Street Area and Greater London in 1880 and 1914 respectively.

Post-Graduate Study

Most medical students in the Victorian period who went abroad for post-graduate qualifications, attended the chief medical schools of Paris, Vienna and Berlin. William Rutherford calculated that five British medical students studied during the winter session in Berlin in 1864, and six studied during the spring term at Vienna, whilst Paris had considerably more. Thus, in the early-to mid Victorian era the numbers who studied at continental schools were low.⁸⁸ According to Rutherford, who analysed the medical schools on the continent in the late 1860s, the best surgical school was considered to be in Paris, which remained a popular choice for the Harley Street cohort until 1914.⁸⁹ In the decade from 1864 to 1874, 13 of the arrivals to Harley Street studied at Paris, whereas in the decade leading up to 1914, 18 new arrivals studied there. Table 3.11 Appendix C, showed that almost 10 per cent of those registered in Harley Street before 1914, continued their education at

⁸⁶ Rivington, *Medical Profession*, pp. 677-678.

⁸⁷ Heaman, *St. Mary's*, p. 85

⁸⁸ William Rutherford, 'The Chief Medical Schools of the Continent', *Edinburgh Medical Journal*, Vol. XI, July 1865 to June 1866, p. 342.

⁸⁹ *Ibid.*

the University of Paris and the majority of these (56 per cent) were surgeons, the balance was GPs (28 per cent) and Physicians (16 per cent).

Berlin also had a good reputation for surgical teaching and was deemed the best school to study pathology. The founder of modern pathology, Rudolf Virchow (1821-1902), established the Institute of Pathology in Berlin in 1856, which became the model for nineteenth century medical schools that taught pathology in Vienna and the rest of Germany. His lectures were always "singularly interesting and instructive, and form[ed] the best course on pathology given on the Continent".⁹⁰ Consequently, medical schools in these countries became renowned for their teaching of the subject.

One of the cohort who studied pathology under Virchow was George Harley.⁹¹ Following his graduation from Edinburgh University and a short period at Edinburgh Royal Infirmary, Harley spent five years studying on the Continent. He moved to Paris to study gun shot wounds among the victims of the Napoleonic *coup d'état* of 1851 and went on to work in a number of physiological and chemical laboratories including those of the French chemist, Charles Adolph Würtz (1817-1884).⁹² In 1853, he moved to Würzburg to study histology under the Swiss physiologist and histologist Albert von Kölliker (1817-1905), and later moved to Virchow's laboratory to study pathology. It was time well spent, as on his return to London in 1855,

⁹⁰ Rutherford, 'Medical Schools', p. 346

⁹¹ Keetley, *Medical Profession*, p. 87 and Abraham Flexner, *Medical Education, A Comparative Study*, (New York, 1925), p.33.

⁹² Anon, 'George Harley', *BMJ*, Vol, II, Oct. 31, 1896, p. 1354 and Mrs Alec. Tweedie, (ed.) *George Harley F.R.S. or the Life of a London Physician*, (London, 1899), pp. 34-120.

Harley was appointed lecturer of Practical Physiology and Histology at University College.

Like his father, Harley's son Vaughan also gained his post graduate experience abroad, working with the pioneer of Tropical Medicine, Sir Patrick Manson (1844-1922) and then spending four years studying in Leipzig, Turin, Vienna, Budapest and Christiania and working in Paris for Louis Pasteur (1822-1895). The knowledge acquired during his post graduate years led Victor Horsley to invite Vaughan to set up the first department of pathological chemistry in England in 1893.⁹³

A number of the Harley Street cohort who had an interest in neurology, such as Gordon Holmes, studied in Germany. Following his MB from Trinity College Dublin, Holmes pursued his studies first in Berlin and then at the Senckenberg Institute at Frankfurt-an-Main where he undertook neuroanatomical research under the guidance of the German neurologist and founder of comparative neuro-anatomy Ludwig Edinger (1855-1918).⁹⁴

From the 1880s, Vienna was often the first choice for those who wished to study the diseases of the skin and gynaecology. It was an increasingly preferred choice for the Harley Street group up to 1904, (based on arrivals to 1914) thereafter its popularity waned slightly, decreasing from 22 students who studied in Vienna (of the arrivals) in 1895-1904 to 13 (of the arrivals) in 1914. In total 8.07 per cent of the cohort gained post-

⁹³ Anon, 'Vaughan Harley', *BMJ*, June 2, 1923, p. 956.

⁹⁴ Davis Coakley, *Irish Masters of Medicine*, (Dublin, 1992), pp. 255-56.

graduate experience at the University of Vienna and the majority of these later became surgeons. Rutherford argued that before the middle of the nineteenth century medical students wishing to study a speciality such as diseases of the eye were better served by the continental medical schools.⁹⁵

A number of post-graduate schools were established in Britain by the end of the nineteenth century. The West London Hospital was the first general hospital in London to offer post-graduate teaching.⁹⁶ By the beginning of the twentieth century, newly established post-graduate Colleges included the North East London Post-graduate College established in 1902, largely through the efforts of the Harley Street medical practitioners Robert Murray Leslie, Arthur John Whiting and Herbert William Carson. This soon became very popular, being recognised by the Navy and the India Office as a suitable place for further education.⁹⁷

Towards the end of the nineteenth century, the acquisition of postgraduate diplomas in specialist areas such as public health became increasingly important for the cohort. Diplomas in special branches of medicine began in 1870 with the Diploma in State Medicine, Trinity College, Dublin, followed by Cambridge University's Diploma in Public Health (DPH) in 1875. Fifteen of the cohort obtained a DPH, beginning in 1879 with Cuthbert Chapman Gibbes, who in common with 12 of the cohort gained his diploma from Cambridge. One obtained an Oxford DPH, whilst two were from UCL.

⁹⁵ Rutherford, 'Medical Schools', p. 347

⁹⁶ Digby, *General Practice*, p. 61.

⁹⁷ Anon, 'Herbert William Carson', *Lancet*, Sept. 6, 1930, p. 556.

Postgraduate Prizes

The range of postgraduate prizes was extensive: the Royal Colleges, universities and medical societies all had a range of fellowships and awards for post graduate research or for contribution made to advances in medicine or science. The first and the most well known prize granted by the RCS from 1800 was the Jacksonian, which was awarded to the candidate with the best essay on a practical subject in surgery.⁹⁸ A year after he moved to Wimpole Street in 1851, Henry Thompson (later Sir) became FRCS following the publication of his essay on *Urethral Stricture* for which he was awarded his first Jacksonian Prize. This work brought him considerable notoriety when a member of the Société de la Chirurgie de Paris plagiarized it. As a result, this member was expelled and Thompson was invited to Paris by the Society. Whilst there, he worked with the renowned surgeon and urologist Jean Civiale (1792-1864) who introduced him to the method of compressing bladder stones which Thompson used so effectively in 1863 on Leopold, King of the Belgians and uncle to Queen Victoria. Thompson won his second Jacksonian Prize in 1860 for his work on the prostate gland: after the successful operation on King Leopold, his reputation was established. "The king improved so much that his recovery was referred to as a miracle and the surgeon who had cured him 'became the hero of the hour at the Belgian Court'. His fame spread on the Continent and patients came to him from all parts."⁹⁹

⁹⁸ Zachary Cope, *The History of The Royal College of Surgeons of England* (London, 1959), p. 32.

⁹⁹ Merrington, *University College Hospital*, pp. 71-72

Postgraduate prizes and scholarships, such as the Syme Bacteriological Scholarship from Edinburgh University, the Queen's Medals from the Royal Society or the Radcliffe travelling fellowship awarded by Oxford, were both a mark of distinction and could be a useful source of funds.¹⁰⁰ Following his graduation from Edinburgh University, William Watson Cheyne used a legacy of £150 to study bacteriology in Vienna and Strasbourg. When he returned to Edinburgh in 1876, he undertook a number of bacteriological experiments and won the Syme scholarship that gave him £100 a year for two years. The Radcliffe Travelling Fellowship was awarded to several of the cohort, including Reginald Southey in 1860.¹⁰¹ The fellowship was open to students of medicine, who had passed their BA degree at Oxford, gained a first class degree in one of the public examinations of the university and had won a university prize or scholarship. Three such awards were granted annually and held for three years with an annual value of £200. The purpose of the fellowship was to promote postgraduate study abroad.¹⁰²

The most common honorary degree awarded to the cohort was the LLD: ten of the cohort, including Henry Head, were granted honorary LLDs. Other honorary degrees were MDs (from Belfast for Frederick Price and Hildred Carlill and from Dublin for Richard Quain and William Hale

¹⁰⁰ The Royal Society had a range of medals and most such as the Davy Medal or the Hughes Medal relate to science subjects. However, the Queen's Medals awarded to George Busk (1871) and Henry Head (1908) were for contributions to the advancement of natural knowledge.

¹⁰¹ Others included Herbert Pennell Hawkins, John Seymour Sharkey, David Forsyth and William Henry Corfield.

¹⁰² Rivington, *Medical Profession*, p. 589.

White). Several universities and licencing bodies conferred honorary degrees on distinguished Harley Street men; Sir Richard Quain, for example, was awarded an LLD (Edin., 1889), MD (TCD, 1890), MD (RUI, 1887) and the FRCPI.¹⁰³

Conclusion

An analysis of the three years 1845, 1880 and 1914 shows that the basic registerable qualification changed from 1845 to 1880 and again in 1914. In 1845, the most common qualifications for medical practitioners in Greater London were the MRCS (28.72 per cent), LSA (11.88 per cent) or a combination of the two (36.63 per cent). Whilst the combined MRCS/LSA (21.31 per cent) was still popular in 1880, there was a decrease in the proportion of medical practitioners who held the single qualifications of LSA (4.06 per cent), MRCS (11.68 per cent) or LM (2.03 per cent). By 1914, this percentage had been reduced further so that only 5.75 per cent held a single licence: LSA/LMSSA only 4.24% ($n = 14$), MRCS or LRCS only, 1.21% ($n = 4$), LRFPS only 0.30% ($n = 1$).

In Harley Street the single licence also became less popular from 1845 to 1914: in 1845, 37.50 per cent held a single licence; in 1880, this had been reduced to 7.01 per cent and by 1914, it had fallen to 1.80 per cent. This downward trend was in line with what was happening in the rest of the medical profession in London and was a reflection of the changes in medical legislation mentioned earlier in this chapter. As Roy Porter argued, from the middle of the nineteenth century,

¹⁰³ *Medical Directory*, 1898, p. 320

London's elite physicians and surgeons had ceased to require the creaking armour which Collegiate privileges appeared to provide, for they were establishing themselves in plush positions of professional authority and eminence. The distinction of a Harley Street practice, combined with consultancy at a leading London hospital, with patients referred by one's former pupils for whom one had found preferable practices: these features ensured that medicine continued hierarchical even after the old corporations finally had their teeth drawn.¹⁰⁴

Within this hierarchy, the most popular qualification for the Harley Street group in the period under investigation remained constant: a combination of the fellowship of the RCP or RCS with a medical degree.

The vast majority — almost 9 out of every 10 (86.00 per cent, $n = 565$) of medical practitioners in Harley Street were qualified MD, MB, FRCP, FRCS or MRCP or held a combination of a medical degrees and fellowships. A considerable number of these men in comparison to medical practitioners in England pursued postgraduate studies abroad and they received more prizes, scholarships and awards during their graduate years than other medical practitioners either in the Harley Street Area or across other parts of London. Harley Street men were quite clearly among the most highly qualified medical practitioners in England, and were at the very pinnacle of the medical academic élite in London. The next chapter examines the cohort's hospital and teaching posts and the emergence of medical specialists within the group.

¹⁰⁴ Roy Porter, *Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900*, (London, 2001), p. 255.

CHAPTER 4

Establishing and Developing a Career: Hospital and Teaching posts

The period from the 1850s to the First World War witnessed a surge in the growth of hospitals, particularly with the foundation of specialist hospitals, and other charitable institutions such as dispensaries, infirmaries, cottage hospitals, convalescent homes, *friedenheims* (for terminally ill cancer patients), orphan and lunatic asylums.¹ Moreover, the range of specialist subjects in various areas of medicine and surgery proliferated with great rapidity. These developments were coextensive with the range of hospital appointments held by Harley Street men, which were across an array of teaching, royal, general and specialist hospitals.

Whilst Harley Street men were employed part-time by a variety of corporate and public institutions such as assurance companies and schools, these posts will not be analysed in this chapter. Though these duties occupied some of their time, the greater part of the cohort's work was spent in private practice and their hospital appointments. This chapter will, therefore, examine the creation of specialist hospitals during the Victorian period, as they relate to the hospital and teaching posts held by the Harley Street men. The growth in specialism in medicine and surgery will be examined *vis-à-vis* the contributions that the cohort made to these emerging areas of expertise. In common with Chapter 3 on education, a comparative

¹ M. Jeanne Peterson, *The Medical Profession*, (London, 1978), pp. 262-263 and Richard Kershaw, *Special Hospitals*, (London, 1909), pp. 38-39.

analysis was undertaken to establish if Harley Street men were appointed to a higher proportion of senior hospital and teaching posts than those in the Harley Street Area and Greater London.

Bill Bynum has remarked, "hospitals have long been a popular topic for historical work, and few hospitals of much antiquity have not had their history written".² The history of British hospitals is disparate, varying enormously from pamphlets and pictorial accounts to monographs. Many of the histories, such as H. Cameron's *Mr Guy's Hospital*, or J. Blomfield's *St. George's*, H. Willoughby Lyle's, *King's and Some King's Men*, were commissioned by the hospital; consequently, they were frequently written by a retired consultant from the Alma Mater. Whilst these are very useful accounts of the foundation and administration of hospitals and the students and teachers of their medical schools, they often offer nothing more than an uncritical assessment of the institution.³ Recent scholarship of individual hospitals, by such historians of medicine as Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker, and Keir Waddington's *The History of Bethlem*, Elsbeth Heaman's *St Mary's* and Keir Waddington's *Medical Education at St. Bartholomew's Hospital*, offer a more critical analysis of their subject.⁴ As the history of various hospitals and the development of specialism has

² W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge, 1995), p. 231.

³ H. Willoughby Lyle, *King's and Some King's Men*, (London, 1935), Hector Charles Cameron, *Mr Guy's Hospital*, (London, 1954) and J. Blomfield, *St. George's, 1733-1933*, (London, 1933).

⁴ Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker, and Keir Waddington, *The History of Bethlem*, (London, 1997), E. A. Heaman, *St Mary's, the History of a London Teaching Hospital*, (London, 2003) and Keir Waddington, *Medical Education at St Bartholomew's Hospital, 1123-1995*, (Suffolk, 2003).

been well covered by historians, these topics will not be discussed in detail in this thesis.⁵

There are no published accounts that offer a taxonomical classification of hospitals, dispensaries, infirmaries and other charitable institutions during the Victorian period. Whilst a variety of directories are available, which include details of these establishments, such as the number of patients, annual income accrued and staff appointments, there were, however, too many variables to allow for a coherent taxonomical classification of hospital and voluntary organisations in relation to their status.⁶ Whilst historians and the medical profession accept that the London teaching hospitals are the most prestigious, because of their longevity, size, patronage and high calibre staff, creating a hierarchy of all the other medical institutions would have been problematic. The Royal Eye Hospital, St George's Circus, Southwark, for example, would have fallen into both the 'Royal' and the 'Specialist' category. If the number of beds or the income of the hospital were used as a criteria then The Establishment for

⁵ For a general history on the development of hospitals see, Brian Abel-Smith, *The Hospitals. A Study in Social Administration in England and Wales, 1800-1948*, (London, 1964), Lindsay Granshaw and Roy Porter, *The Hospital in History*, (London, 1990). There is a vast amount of scholarly material on individual hospitals, which includes Lyle, *King's*, *passim*, Cameron, *Guy's*, *passim*, and Blomfield, *St. George's*, *passim*, Andrews, et al *Bethlem*, *passim*, Heaman, *St Mary's*, *passim* and Waddington, *Bart's*, *passim*. For the development of medical specialism see, for example, Rosemary Stevens, *Medical Practice in Modern England, the Impact of Specialization and State Medicine*, (London, 1966), Charles Newman, *The Evolution of Education in Britain*, (London, 1966), George Rosen, 'Origins of Medical Specialism', *Ciba Symposia*, Vol. 2, (1949-51), Horatio Bryan Donkin, 'Dangers of Medical Specialism', *The Fortnightly Review*, (London), July, 1885, pp. 67-78, Morell Mackenzie, 'Specialism in Medicine', *The Fortnightly Review*, (London), June, 1885, pp. 772-787.

⁶ See, for example, Sir Henry Burdett, *Hospitals and Charities*, (London, 1902), *Kelly's London Medical Directory*, (London, 1896), Charles R. Hewitt, *The Medical Year Book*, 1924, (London, 1924), Sampson Low, junior, *The Charities of London in 1861*, (London, 1862).

Gentlewomen during Temporary Illness, Harley Street, with an average number of 20 beds and an annual income of £1,885 in 1902, would have ranked higher than the Royal Ear Hospital, Frith Street, which had an average number of 9 beds and an annual income of £772 in the same period.⁷ Imposing some sort of classification onto institutions that were changing over the nineteenth century would have posed additional problems. By the first quarter of the twentieth century, for example, many infirmaries and Poor Law hospitals were remodelled as general hospitals, serving the general public and not just the poor.

Hospital Appointments held by London Medical Practitioners

Historians have acknowledged the problem of classification of medical men, as the boundaries in the Victorian medical world were fluid.⁸ Determining the type of practice undertaken by the cohort from the records in *Medical Directory* and obituaries, could not always be ascertained with certainty. Frequently, too little information was given in these records to establish the type of practice pursued. Qualifications could not be used as an exact indicator of the individual's status or type of practice. For example, 17 of the cohort held both the FRCP and the FRCS; other sources such as obituaries had to be used to ascertain the nature of their practice. As Digby found "the distribution of practising generalists relative to specialists cannot always be plotted precisely because the boundary was both permeable and changing". At the beginning of the nineteenth century, a consultant was defined as

⁷ *Ibid.*

⁸ Anne Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford, 1999), p. 6 and Dupree and Crowther, 'Medical Profession in Scotland', pp. 223-225

someone who was an Oxbridge graduate and FRCP or FRCS and on the staff of one of the large general hospitals.⁹ Thus, the physician Charles Bell Keetley recommended that if a student wished to become a consultant or specialist, he should take a house-surgeoncy or house-physiciancy and take either the MRCP or FRCS.¹⁰ This definition did not remain static over the course of the century, as historians and the medical profession have described its changing meaning over time.

A consultant in the mid- to late-nineteenth century usually indicated that the medical practitioner had retired from hospital work. Senior physicians and senior surgeons of the teaching hospitals, in particular, were often given the honorary position of “consulting physician” or “consulting surgeon” on their retirement from the permanent staff, “usually between the age of 60 and 65 or after twenty years service, according to the rules of the particular hospital. They received no emolument and were not permanent members of staff”.¹¹ The physician, Sir Walter Langdon-Brown, remarked in the 1930s that “a physician to a hospital who has been relegated by *anno domini* to what is known as the ‘consulting staff’, has a position of great dignity but of no importance”.¹² By the end of the nineteenth century, however, the distinction between consultant and specialist had become blurred. Andrew Morrice considered that the role of a consultant was determined by the central ethical committee of the BMA in 1909. In the

⁹ J. Johnston Abraham, *Ninety-Nine Wimpole Street*, (London, 1937), p. 59.

¹⁰ Charles Bell Keetley and Robert Wharry, eds., *The Students and Junior Guide to the Medical Profession*, 2nd edition, (London, 1885), p. 39

¹¹ Walter Rivington, *The Medical Profession*, (Dublin, 1888), pp. 664-665.

¹² W. Langdon-Brown, ‘Crabbed age and youth’ in Sir Henry Bashford, (ed.) *Doctors in their Shirt Sleeves* (London, 1939), p.1.

BMA report on the ethics of medical consultation, a consultant was defined as:

any practitioner who is called upon to give a second opinion respecting a case already under the care of another practitioner [and] the term is frequently used also as the designation of a special class of medical practitioner, distinguished ... by the fact that a proportion of the patients attended by him are seen in consultation with, or ordinarily under the care of other practitioners.¹³

A dichotomy in the medical profession in Britain was evident by the 1840s. Thomas Neville Bonner remarked that 80 per cent of medical practitioners were engaged in general practice, whilst “the more academically trained physicians and surgeons, usually members of the royal colleges, were concentrating their practices more and more in and around the hospital centres of London”.¹⁴ Bonner further acknowledged that fees earned from consultancy and private practice together with teaching emoluments allowed these men “to continue as members of the elite”.¹⁵ According to Anne Hardy the division between general practitioner and the hospital consultant who also ran a private practice was evident from the 1860s,

at the top of the scale were the consultants, who by 1900 had firmly established themselves as the élite of the profession operating private practices, often based in the Harley Street Area of London, but also in provincial towns and cities.¹⁶

¹³ Andrew Morrice, “Honour and interests”: Medical ethics in Britain, and the Work of the British Medical Association’s Central Ethical Committee, 1902-1939”, (MD, University of London, 1999), pp. 146-47.

¹⁴ Thomas Neville Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945*, (Oxford, 1995), p. 184.

¹⁵ *Ibid.*

¹⁶ Anne Hardy, *Health and Medicine in Britain since 1860*, (Hampshire, 2001), p. 14.

Membership or Fellowship of the Royal Colleges was a prerequisite for a career as a medical consultant.¹⁷ The Harley Street medical practitioner, Gordon Holmes, who became a director of research in clinical neurology at Queen Square, illustrates this point. Holmes had qualified MD in 1903, but as he did not hold the MRCP, a consultancy post in the hospital would have been unlikely. A ruptured Achilles tendon forced him to give up clinical research and provided him with the time to study for the MRCP, which he passed in 1908. Subsequently he applied for a consultancy post at Queen Square and was elected on the narrow margin of one vote. During the meeting, John Hughlings Jackson, physician at Queen Square,

who was then quite elderly and too deaf to hear the committee's discussion about various candidates, asked the consultant next to him who he should support. The consultant wrote 'HOLMES' on a piece of paper and Jackson cast the deciding vote.¹⁸

Rivington classified medical practitioners in the late 1880s as:

physicians, surgeons, obstetricians, general consulting physicians and specialists. Physicians, or pure physicians, or consulting physicians, whether specialists or not, practise, or are supposed to practise, medicine only. After passing the ordinary qualifying examinations, or, in the first instance, they have usually become members or fellows of a college of physicians and doctors of medicine of one of the universities.¹⁹

Rivington's organisation of the medical profession was a useful taxonomical tool for the period. By applying his categorization to the cohort, 256 (38.96%) Harley Street men would be defined as "pure physicians", (FRCP, MD or MRCP), 244 (37.14%) as "pure surgeons" (FRCS or MS) and only a quarter (23.90%, $n = 157$) as general practitioners. Using Rivington's definition, 76.10 per cent of the cohort could be viewed as pure physicians or pure

¹⁷ Rivington, *Medical Profession*, p. 666.

¹⁸ Davis Coakley, *Irish Masters of Medicine*, (Dublin, 1992), pp. 255-56.

¹⁹ Rivington, *Medical Profession*, p. 277.

surgeons. Thus, Harley Street could be seen as a nucleus of the medical and surgical élite.

The various categories of medical practitioner were, however, mutable in the nineteenth century. The inconsistent nature of the classification of Victorian medical practitioners can be seen in a number of the cohort who referred to themselves as general practitioners, such as Sir Morton Warrack Smart and Sir James Mackenzie, but who were, in principle, consultant specialists. Smart was the manipulative surgeon to George VI and Mackenzie was an internationally renowned heart specialist. Whether the cohort were styled physicians, surgeons, general practitioners, consultants or specialists, or, indeed, a construct of these, depended on a number of factors such as self-perception and the obituarist's perspective. Professional status was also a question of economics; it was advantageous for medical practitioners to develop a particular interest in a medical or surgical field on which they could build their reputation. Since

the public do not believe in universalism as applied to the practice of medicine, but pin their faith on the specialist who has "Taken up" or is "Good for" some particular ailment or organ. Some specialists take up three or four specialists at the same time besides the rest of the body.²⁰

Historians agree that few medical practitioners were specialists by the 1850s and of this minority most worked in London.²¹ Digby asserted that:

although some [historians] have seen a new and divided professional structure based on a clearly defined difference between GP and consultant

²⁰ Rivington, *Medical Profession*, pp. 277-278.

²¹ R. S. Downie and Bruce Charlton, eds., *The Making of a Doctor, Medical Education in Theory and Practice*, (Oxford, 1992), p. 18 and Digby, *General Practice*, pp. 37 and 289.

occurring even before 1850, it is more accurately seen as a phenomenon confined mainly to London where a small minority practised as specialists.²²

Up to the end of the nineteenth century only a minority of the medical profession who were not on the staff of a large hospital were able to build a successful private practice. F. N. L. Poynter acknowledged that in the Victorian period, hospital appointments served as an indicator of success, which also had pecuniary benefits since they provided an opportunity to gain salaried teaching posts.²³ A number of the Harley Street physicians such as, Henry G. Wright and Sir Richard Quain and the surgeon, Sir Charles Ryall managed to circumvent this standard system, but this was unusual for the period. Wright who only held “minor hospital appointments” including being physician to the Samaritan Hospital, acquired a position in practice and in the profession, which “men ‘out of the hospital groove’ [found] it very difficult to acquire”.²⁴ Similarly, Quain had never been on the staff of a teaching hospital, but managed to built a large and profitable practice in Harley Street where many of his patients came from the “upper strata of society”.²⁵ When Ryall, senior surgeon to St Mark’s Hospital and Bolingbroke hospital was elected to the Council of the RCS (1914-1922), it was an “unprecedented” decision, as he was not on the staff of a teaching hospital and could, therefore, “not command the support ensured by such a position”.²⁶

²² Digby, *General Practice*, p. 289.

²³ F.N.L. Poynter, (ed.) *The Evolution of Medical Practice in Britain*, (London, 1961), p. 111.

²⁴ Anon, ‘Henry G. Wright’, *BMJ*, Jan. 16, 1869, p. 62.

²⁵ Anon, ‘Sir Richard Quain’, *Lancet*, Mar. 19, 1898, p. 798.

²⁶ Anon, Sir Charles Ryall, *BMJ*, Sept. 16, 1922, p. 534.

Harley Street consultants worked part time in one or more of the hospitals. As resident consultants they usually had their board and lodging paid for, but in general did not receive a salary.²⁷ If a medical practitioner was on the teaching staff, early mornings were for delivering lectures; these were followed by house calls and hospital visits that usually took place around lunchtime.²⁸ In the afternoon, they typically received private patients in their consulting rooms.

Table 4.1, Appendix D, shows the hospital affiliation of the Harley Street group. As the majority of the institutions where the cohort held staff posts were numerically small, this table includes only those hospitals in which one per cent or more of the cohort had a staff appointment. Posts held on arrival in Harley Street and at the year of their departure from the Street are included in this Table. Hospital posts were not mutually exclusive, as many of the cohort, particularly distinguished consultants, held multiple posts in a variety of different hospitals, which will be discussed later in the chapter.

Hospital Appointments held by Harley Street Men

The range of staff appointments held by the cohort was extensive and included posts across a variety of 526 different institutions. Henry Burdett calculated that by 1896 there were some 300 cottage hospitals in England

²⁷ Provincial Consultants could earn £80 to £100 in the mid 1880s according to Keetley in Charles Bell Keetley and Robert Wharry, eds., *The Students and Junior Guide to the Medical Profession*, 2nd edition, (London, 1885), p. 40.

²⁸ Rivington, *Medical Profession*, pp. 277-278.

where patients paid for their medical care according to their means.²⁹ In the same year *Kelly's*, directory of London listed 186 special institutions in London alone (apart from cottage hospitals). These hospitals dealt with various diseases or groups of patients, for example, 51 hospitals and convalescent homes were devoted to children, 12 to midwifery and five to skin diseases.³⁰ In the same period, Britain had 66 county asylums and a large number of private asylums were built to deal with the increasing number of mentally ill patients, which rose from a few thousand inmates in 1800 to over 100,000 in 1900.³¹ In total, over 90 per cent of the cohort held staff posts in one or more of a variety of these 526 institutions in England, though these were mainly confined to Greater London. Dupree and Crowther, who found the range of hospital posts to be confusing, highlighted the difficulty in summarising hospital posts for their early twentieth century cohort of Scottish medical practitioners, as many of the entries in the *Medical Directory* could not be found in standard sources such as *Burdett's Hospitals and Charities*.³²

Recruitment

The vast majority of students who eventually became consultants on Harley Street, gained their hospital posts from their Alma Mater. This was best exemplified by four of London's most prestigious hospitals: St Thomas's

²⁹ Henry Burdett, *Cottage Hospitals, General, Fever and Convalescent: their Construction, Management and Work*, (London, 1896), p. 6.

³⁰ *Kelly's London*, 1896, pp. 376-407.

³¹ Roy Porter in *Cambridge Illustrated History: Medicine*, Roy Porter, (ed.), (Cambridge, 1996), p. 296.

³² Marguerite W. Dupree and M. Anne Crowther, 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: The *Medical Directory* as a Historical Source', *Bulletin of the History of Medicine*, Vol. 65, 1991, pp. 223-24.

could boast that 95% of its Harley Street staff members had trained at the hospital's own medical school, followed by Bart's with 88%, UCH with 87%, and Guy's at 86%. The other four teaching hospitals demonstrated that the majority of their staff from Harley Street had also trained at the medical school attached to the hospital in which they later worked: St Mary's (65%), the London (63%), King's (61%), George's (58%), and the Middlesex (54%). Only a quarter of the men (27.27%) who held a staff post at Westminster Hospital, and none from the Royal Free, completed their training there. This was not surprising since Westminster and the Royal Free were not large medical schools and did not offer the full medical curriculum. Only students preparing for the final examination were tutored; preliminary and intermediate examinations were taken at King's College.³³

This pattern of employment in the London teaching hospitals corroborates the view amongst historians of medicine who have shown that recruits to staff positions in the London teaching hospitals were selected from their own body of students.³⁴ Thus as Peterson found, nineteenth-century hospitals continued to "favour their own".³⁵ When the teaching hospitals did not employ members from the cohort who had trained at their medical schools, graduates from the largest medical school, Bart's, usually filled their staff vacancies. As the demand for appointments at the London teaching hospitals far outstripped supply, many of the cohort had to find work at another hospital. Thus, Edward Arthur Saunders, who had

³³ S. Squire Sprigge, *Some Considerations of Medical Education* (London, 1910), p. 64.

³⁴ See, for example, Peterson, *Medical Profession*, p. 161 and Heaman, *St Mary's*, p. 43.

³⁵ Peterson, *Medical Profession*, p. 161.

graduated MB from Oxford in 1894, became FRCP in 1910 and completed his training at St Thomas's Hospital, was forced to apply elsewhere. Even one of his colleagues realised that Saunders was unable

to find a footing in his own hospital—such appointments [were] few in comparison to suitable applicants. Hence like others he journeyed west and in 1899 was appointed assistant physician and pathologist to the West London Hospital.³⁶

The medical schools attached to the London teaching hospitals also recruited their teachers and lecturers from within. The pattern of recruitment for teaching posts was remarkably similar to that of hospital appointments. Virtually all of the cohort who taught at St Thomas's had also trained at their medical school (94.74%), followed by Bart's (88.89%), Guy's (85.71%), UCH (72%), Mary's (66.67%), the London (66.67%), George's (63.64%), Middlesex (57.69%) and King's (47.62%). Only 25% of those appointed at Westminster and none of those from the Royal Free had trained there.

The Development of Specialism and Special Hospitals

Until the nineteenth century, specialism did not threaten the livelihood of medical practitioners, nor did it conflict with the work of general hospitals or charitable institutions. Indeed, the early special hospitals dealt with the kinds of diseases, such as insanity, venereal disease and smallpox, which general hospitals were not willing to admit and physicians were reluctant to treat.³⁷ Since the emergence of medical specialism was a gradual process, this makes it problematic to assign a specific beginning to an particular area

³⁶ Anon, 'Edward Arthur Saunders', *Lancet*, Sept. 27, 1947, p. 494.

³⁷ Charles Newman, 'The Rise of Specialism and Postgraduate Education', in Poynter, *Medical Education*, p. 175.

of expertise. The study of the various diseases that would later become specialties were not new to the nineteenth century, but the increase in medical knowledge and the development of new instruments enabled medical practitioners to concentrate on a particular organ or a particular disease.

Before the knowledge of many diseases or organs became sufficiently established, medical practitioners often dealt with a number of special areas. Such groupings included: ophthalmic and aural surgery, paediatrics and obstetrics, pathology and bacteriology, whilst dermatology was often combined with syphilology (venereal diseases). Table 4.2, Appendix D shows the medical and surgical specialities practiced by the Harley Street group. This Table also displays the special interests of the group, defining special interest as a practice which was largely, though not exclusively of a specialist nature.

By the 1890s Harley Street, according to the historian Edward Shorter, had become the nucleus of London's consultant and speciality practice.³⁸ Indeed, over half of the Harley Street men were medical or surgical specialists or had a special interest in one or more subject. Many, no doubt, were attracted by the potential income gained in being recognised by the public as a specialist. As the Victorian physician, Jukes De Styrup remarked in the 1880s,

as every elder, time worn practitioner knows, it is almost impossible to become rich by the practice of medicine, unless it be by some *speciality*,

³⁸ Edward Shorter in Roy Porter, (ed.) *Cambridge Illustrated History: Medicine*, (Cambridge, 1996), p. 146.

commanding heavy fees and many specialists did indeed acquire considerable fortunes in the period.³⁹

Some physicians, such as Horace Benge Dobell and Edward Collett Hort, were working in fields that had not yet become established specialities; thus, they could only be viewed as specialists retrospectively. Dobell, who was appointed consulting physician to the Royal Hospital for Diseases of the Chest (1858-1892), worked almost exclusively on diseases of the chest and pulmonary tuberculosis. However, he was part of the "old school before specialism developed, and while he aspired to be master of one part of his art he kept up his general knowledge".⁴⁰

Hort, who had been a general practitioner in Torquay was nearly 40 when he decided move to Harley Street to concentrate on bacteriology, which he "henceforth pursued with ceaseless, almost feverish, energy ... every spare moment was devoted to research work."⁴¹ Whilst he was not considered a specialist in his own lifetime, Dr J. G. Adami, Vice-Chancellor of the University of Liverpool remarked in 1922, "I am convinced that future years will establish Hort as one of the masters in bacteriology".⁴² A number of the cohort, such as George Buckston Browne devoted most of their life's work to a chosen field, yet they were not viewed contemporaneously as specialists. Browne, who in the last quarter of the nineteenth century was, "one of the busiest surgeons of his day, as he saw patients morning, noon and night" and took no holiday for 25 years, made his name as an expert on

³⁹ Jukes De Styrup, *The Young Practitioner*, (London, 1889), p. 227.

⁴⁰ Anon, 'Horace Benge Dobell', *Lancet*, Mar. 10, 1917, p. 391.

⁴¹ Anon, 'Edward Collett Hort', *BMJ*, Oct. 21, 1922, p.777.

⁴² Dr. J. G. Adami, 'Edward Collett Hort', *BMJ*, Oct. 21, 1922, p. 778.

diseases of the genito-urinary tract. Although the bulk of his practice was in urology, for which he invented a number of surgical instruments and many more were developed for him, he also saw a few general patients and hence was referred to, at the time, as a general surgeon.⁴³

Anomalies were common between perception and practice: even distinguished specialists such as Charles Edward Beevor and Frederick Still, who were prominent in their field, presidents of specialist societies, and writers and orators on their chosen subjects, were not regarded as specialists at the time.⁴⁴ A few of those who specialised in a particular area resisted being classed as “specialists”. Percy Sargent who made cerebral surgery his speciality, claimed he “never wished to pose as a specialist ... [which] ... prevented him from publishing the wealth of material in his special branch”.⁴⁵ Whether one was classified as a specialist or generalist may be a reflection of an obituarist’s own agenda, particularly during the nineteenth century when specialism was on the fringe of conventional medical and surgical practice. Therefore, in deference to the deceased, an obituarist may refer to his subject’s broad interest in medicine. Charles Edward Beevor’s obituarist, for example, recorded in 1908, that Beevor showed “a bent towards neurology”. Victor Horsley, with whom Beevor worked at the Brown Institution noted that Beevor’s experimental and clinical research had “not only notably forwarded neurology in its most

⁴³ The inventions of Sir George Buckston Browne are listed in Jessie Dobson and Sir Cecil Wakeley, *Sir George Buckston Browne*, (London, 1957), p. 140

⁴⁴ Beevor delivered the Croonian Lecture (1907) and the Lettsomian Lectures (1907) on the results of his research into the nervous system, which were published by the Royal Society, he was also President of the Neurological Society before it merged with the RSM in 1907.

⁴⁵ Anon, ‘Sir Percy Sargent’, *BMJ*, Jan. 28, 1933, pp. 167-69.

practical aspects, but has greatly contributed to enhance the character of this branch of applied science in Great Britain". Yet, Beevor's obituarist noted that "although [he] specialised he was interested in the whole field of medicine."⁴⁶

Keetley argued that by 1885 there was a movement towards specialism in the large cities; he thought that there were some areas of medicine or surgery such as those connected with diseases of the eye or obstetrics, where general physicians and surgeons were badly informed. He deplored the "humbugs" and thought it was "unfortunate that Specialism gives such opportunities to puffery and quackery".⁴⁷ In June of the same year, the Harley Street laryngologist Morell Mackenzie praised the virtues of specialism in *The Fortnightly Review*, whilst his Harley Street neighbour, Horatio Bryan Donkin lambasted Mackenzie for holding such views and warned of the dangers of specialism.⁴⁸ Mackenzie believed that specialism originated within the medical profession, even though it was going on in the physical and biological sciences at the same time. Like many successful specialists, Mackenzie also thought the public opinion had "declared itself with such emphasis on the side of the specialists' profession that the [medical] profession ha[d] been coerced into [a] sullen acquiescence in the inevitable".⁴⁹ Thus, the public voice decisively approved of the existence of specialists, which also meant that young physicians could be more receptive to the idea. Donkin countered that Mackenzie did not provide a definition of

⁴⁶ Anon, and Sir Victor Horsley, Charles Edward Beevor, *BMJ*, Dec. 12, 1908, pp. 1785-86.

⁴⁷ Keetley, *Medical Profession*, p. 47

⁴⁸ Donkin, 'Specialism', *passim*, Mackenzie, 'Specialism', *passim*.

⁴⁹ Mackenzie, 'Specialism', p. 772.

specialism and, therefore, did not have a clear notion of what specialism meant in matters of medicine.⁵⁰ To Donkin, this was nothing new since he thought that specialism in the “wide sense of devotion of special attention ... had existed for a long time”.⁵¹ His main argument was built on the premise that the body was interconnected and could not be studied in a piecemeal fashion. To treat the heart with no regard to the other organs of the human body would not be medically expedient.

These debates were conducted amongst various medical practitioners until well into the twentieth century. The Harley Street chest surgeon, Hugh Morriston Davies, for example, received a considerable amount of criticism from the RCP and his colleagues at UCH in the first decade of the twentieth century for his pioneering thoracic surgery, and he was recognised as an expert only late in his career.

Historians generally accept that by the middle of the nineteenth century, obstetrics and ophthalmology were recognised as areas of expertise. According to Digby,

an authoritative view in 1878 was that they [i.e. specialisms] could be limited to ophthalmics and obstetrics, on the grounds that these were the only areas in which ‘ordinary men are not capable of lecturing, and which they delegate to others’.⁵²

However, other subjects such as urology and laryngology were beginning to emerge as specialist subjects from the 1850s. The recognised specialities of

⁵⁰ Donkin, ‘Specialism’, p. 67.

⁵¹ *Ibid.*, p. 68.

⁵² Digby, *General Practice*, p. 37.

radiology, anaesthetics, paediatrics, neurology and dermatology belong to the late nineteenth century.

Many of the London specialist hospitals in the beginning of the twentieth century also employed specialists from other disciplines. In the 1920s, for example, Norman Harman, a specialist in ophthalmology treated eye diseases at the West End Hospital for Nervous Diseases and Victor Bonney was the gynaecologist at the Hospital for Epilepsy and Paralysis. However, other hospitals, such as the Hospital for Diseases of the Throat, Fitzroy Square, had no facilities for cases other than those concerned with its specialist area.⁵³ There was an ongoing struggle in the legitimisation of medical specialities. The laryngologist, Greville Matheson MacDonald, lamented the lack of respect for specialists, before he moved to Harley Street in the early 1890s, when he remarked:

even a consulting room in Wimpole Street would not give me a place among the really elite. The Throat Hospital, in spite of its new and irreproachable staff, was looked upon by a carefully censorious procession as simply not respectable. The distrust of this newest speciality in medicine was chiefly due to the prevalent disapproval of specialism in general; for it was considered that all qualified practitioners were competent for everything.⁵⁴

Veiled Specialism and Special Interests

Veiled specialism was evident in a number of the cohort whose names became identified with particular specialities, but who also saw other medical cases. Rivington remarked that a special interest or speciality is “taken up” when,

⁵³ Hewitt, *Year Book*, *passim*.

⁵⁴ Greville MacDonald, *Reminiscences of a Specialist*, (London, 1931), p. 388.

a practitioner writes a book, or paper, or a pamphlet, or founds or attaches himself to a special hospital, or the special department of a general hospital, and makes himself known in the branch or branches which he cultivates.⁵⁵

Few medical practitioners throughout London, even in the late nineteenth century, confined themselves exclusively to specialist cases. For example, Gordon Holmes and Aldren Turner saw other patients in addition to those suffering from a neurological complaint. However, Samuel Alexander Kinnear Wilson and George Frederick Still were amongst this minority during the period who restricted their practice to neurology and paediatrics respectively.

The degree of specialism amongst so-called specialists in the Victorian period varied according to the subject. Poynter remarked that whilst ophthalmologists and otolaryngologists rarely saw patients outside of their speciality, rectal surgeons saw themselves as general surgeons specialising in diseases of the rectum, but equally saw patients with other complaints.⁵⁶ The special interests of the mid-nineteenth century, such as children's diseases and diseases of the skin, were to become the established specialities of paediatrics and dermatology in the late nineteenth century. Peterson distinguished between the early quack specialists and the later Victorian consultants and specialists in England: "the latter involved the development and elaboration of institutions – hospitals, societies, and journals – devoted to their subject".⁵⁷ As Roy Porter observed, "specialities

⁵⁵ Rivington, *Medical Profession*, pp. 277-278.

⁵⁶ Poynter, *Medical Education*, p. 177.

⁵⁷ Peterson, *Medical Profession*, p. 260.

flourished when they involved a conspicuous body part or pain responsive to surgical intervention”.⁵⁸

Those medical and surgical fields in which the cohort specialised or had a special interest are shown in Table 4.2, Appendix D and their main areas of expertise are discussed below. There are far too many specialised areas to discuss them all individually, especially as a number of them changed during the period. Particular attention is thus given to those areas that were growing rapidly during the period and to those where the cohort either made significant contributions to the field, such as creating a new discipline or in establishing new special hospitals. Ophthalmology is of particular interest since this was one of the first areas where specialisation in medicine occurred.

Ophthalmology

Although the study of diseases of the eye were greatly assisted by the invention of the ophthalmoscope by Hermann von Helmholtz (1821-1894) in 1851, the prototype for nineteenth century ophthalmic hospitals in Britain, the Royal Ophthalmic Hospital, Moorfields had already been established by John Cunningham Saunders in 1804. It began as the London Dispensary for the Relief of the Poor Afflicted with Ear and Eye Diseases.⁵⁹ By the 1890s, four other eye hospitals were established in London including The Royal Westminster Ophthalmic Hospital (1816) and the Central London

⁵⁸ Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present*, (London, 1999), p. 388.

⁵⁹ Lindsay Granshaw, “Fame and Fortune by means of bricks and mortar’, the Medical Profession and Specialists Hospitals in Britain, 1800-1948” in Granshaw and Porter, *The Hospital*, p. 202.

Ophthalmic Hospital (1843). Approximately half of the senior staff at Moorfields and the Central Hospital and a third of the staff at Royal Westminster in the 1890s were Harley Street men. At Moorfields these included consultant surgeon George Lawson, the surgeons John Tweedy, Arthur Quarry Silcock and assistant surgeons, John Bowring Lawford and Andrew Stanford Morton. Whilst Ernest Clarke, Arthur Poulett Lethbridge Wells were surgeons to the Central, and James Thomas James and Norman Macle hose were assistant surgeons. Lawson, Tweedy, Lawford, Silcock and Morton, were all also on the staff of the Royal in the same period.⁶⁰

A number of Harley Street men were extremely influential in the development of modern ophthalmic surgery in the 1860s and 1870s, and were amongst the few who began their careers as a general surgeons and later switched to working exclusively on diseases of the eye. George Critchett, together with his Harley Street neighbour the ophthalmic surgeon George Lawson, were two of the most prominent specialists in ophthalmology in the period. Other eminent men included the non-Harley Street Sir William Bowman and Jonathan Hutchinson.⁶¹

George Critchett was educated at a private school in Highgate and at 17 became apprenticed to John Scott, surgeon to the London Hospital. George rose through the ranks of the London becoming assistant surgeon in 1846 and full surgeon in 1861. Following the introduction of anaesthesia, George and his colleague, Sir William Bowman, who advised him to

⁶⁰ *Kelly's* 1896, pp. 381, 400 and 401.

⁶¹ Anon, 'Sir Anderson Critchett', *BMJ*, Feb. 14, 1925, p. 338.

concentrate on ophthalmology, played a pivotal role in inventing new surgical procedures on the eye, as well as improving existing practices, such as those for the removal of cataracts. They termed their new surgical procedure “iridesis” or the formation of artificial pupils by tying the iris. George was also very interested in the inflammation of the cornea and his work was fundamental to establishing iridectomy in acute glaucoma.⁶² According to the ophthalmologist Maitland Ramsey, William Bowman and George Critchett

did more than any other two men to raise the standards of British ophthalmology and to make the (*sic.*) Moorfields so widely known that it came to be regarded as the ophthalmic Mecca, from which ophthalmologists came from all parts of the world.⁶³

It was, perhaps, unsurprising that Sir George Critchett's eldest son, Anderson, should become an ophthalmic surgeon, as it was the desire to help his father that drew Anderson to ophthalmology.⁶⁴ Educated at Harrow and later at Cambridge where he took an Arts degree in 1867, Anderson completed his medical training at the Middlesex and qualified MRCS (1872). In 1881 he was elected, against strong competition, to the position of ophthalmic surgeon at St Mary's Hospital. It was here that he established his reputation as a specialist by turning a small ophthalmic department into an “internationally renowned clinic” by the beginning of the twentieth-century.⁶⁵ Anderson received virtually every possible professional honour

⁶² Treacher Collins, *The History of Moorfields Eye Hospital: 100 years of Ophthalmic Discovery and Development*, (London, 1929), p. 92.

⁶³ A. Maitland Ramsay, ‘George Critchett, FRCS’, *The British Journal of Ophthalmology*, Aug. 1923, pp. 4-5.

⁶⁴ Anderson assisted his father when he successfully operated at the International Congress in Paris on a German woman who was blind from a cataract, see *Ibid.*

⁶⁵ Anon, Critchett, pp. 338-39 and Heaman, *St Mary's*, p. 77.

that could be conferred on him, including President of the Ophthalmological Society of the United Kingdom (1899-1901), first President of the Section of Ophthalmology at the RSM (1912), first President of the new Council of British Ophthalmologists (1918) and Master of the Oxford Ophthalmological Congress (1924). As surgeon-occulist to King Edward VII he received a knighthood in 1901 and was made a baronet seven years later. He was not a prolific writer, although he collaborated with his father on the sixth edition of George Critchett's well known text book *Diseases of the Eye*.⁶⁶ Anderson's skill as a surgeon established his reputation as the "doyen of ophthalmic surgeons", and the "recognised leader amongst eye men of all countries".⁶⁷

Like Anderson Critchett, the surgeon Arnold Lawson followed his father, another Harley Street ophthalmologist, into his speciality. Arnold, the fourth son of George Lawson the surgeon oculist to Queen Victoria, was educated at the Merchant Taylors School before proceeding to his medical training at the Middlesex Hospital. He graduated MD, Brussels (1891), took the diplomas MRCS/LRCP (1891) and in 1893 became FRCS. He worked for a time as a clinical assistant to John Tweedy before joining his own father in 1892 at his practice at 11 Harley Street. Arnold developed his reputation there over the next 55 years to become an "eminent ophthalmic surgeon".

Lawson was just one of 55 Harley Street men who rose to prominence by concentrating on diseases of the eye. Of these men, 47 were specialists who all achieved academic success; the majority were FRCS. They were very

⁶⁶ Anon, 'Arnold Lawson', *Lancet*, Feb. 1, 1947, p. 198.

⁶⁷ Anon, Critchett, p. 338.

involved in their speciality, contributing to the literature on ophthalmology, lecturing on their subject, establishing eye hospitals or holding senior positions in the Ophthalmological Society of the United Kingdom.⁶⁸ The cast of eminent consulting ophthalmic surgeons included Sir John Tweedy (UCH), Robert Brudenell Carter (St. George's), Reginald Affleck Greeves (the Middlesex) and Robert Lyell (the Middlesex). Tweedy was particularly well known, as he was Professor of Ophthalmic Medicine and Surgery at UCL, President of the RCS (1903-1906) and Consulting Ophthalmic Surgeon to UCH and Moorfields. At various times he was also President of the Ophthalmological Society of the United Kingdom, of the Medical Society, the Medical defence Union and the Royal Medical Benevolent Fund.

Laryngology and Aural Surgery

As the use of the ophthalmoscope had revolutionised ophthalmic surgery, the development of the laryngoscope transformed laryngology. Invented by the Paris singing-master Manuel Garcia (1805-1906) in 1855, this instrument allowed the practitioner to view inside the organ, which had not been possible previously, and thus helped to establish an interest in the throat. The emergence of laryngology as a specialist subject owes its origin to Morell Mackenzie, referred to as the father of British laryngology, who established the first Dispensary for Diseases of the Throat, Golden Square, the first of its kind in England in 1863.⁶⁹ In his book, *The Laryngoscope*, one

⁶⁸ Robert Brudenell Carter, for example founded the Eye Hospital in Nottingham with a non Harley Street doctor, Dr. Brookhouse. Robert Henry Elliot was a prolific writer and wrote a number of books and papers on ophthalmology, see Anon, 'Robert Henry Elliot', *Lancet*, Nov. 21, 1936, p. 1240.

⁶⁹ Anon, 'Sir Morell Mackenzie' *BMJ*, Feb. 13, 1892, pp. 362-63.

of the first methodical treatises on the diseases of the nose and throat (1880-1881), Mackenzie traced the history of the instrument and argued that although Garcia invented the laryngoscope, Professor Czermak of Pesth (now Budapest) refined the apparatus in 1857 including the substitution of the more reliable artificial light for the rays of the sun. Mackenzie thus argued that laryngoscopes were not useful diagnostic tools before Czermak's time.⁷⁰

As with so many pioneers, Mackenzie's desire to concentrate in a particular area of medicine provoked hostility amongst many generalists who did not see the need for specialism. However, the public were keen on specialists. As another Harley Street laryngologist Greville MacDonald pointed out, "patients all too readily would run after and applaud any newly fashionable practitioner claiming special knowledge".⁷¹ Mackenzie's unorthodox surgical practices caused him to be ostracised by his colleagues and publication of his account of the treatment of the German Crown Prince further alienated him from the medical establishment.⁷² In 1887, Queen Victoria asked Mackenzie to go to Berlin to attend her son-in-law who was suffering from a growth in his larynx; unfortunately, the Prince died in June 1888, possibly due to syphilis.⁷³ In Mackenzie's account of the case, he denigrated his German colleagues, all of whom were established general surgeons, whom he felt had failed correctly to diagnose the Prince's

⁷⁰ Morrell Mackenzie, *The Laryngoscope* (London, 1865), quoted in *Source Book of Medical History*, compiled by Logan Clendening, (New York, 1942), pp. 664-65.

⁷¹ Greville MacDonald, *Reminiscences of a Specialist*, (London, 1931), p. 229.

⁷² Anon, 'Mackenzie', pp. 362-63.

⁷³ Reginald Pound, *Harley Street*, (London, 1967), p. 3.

condition. Mackenzie's attack was seen as a breach of confidence, condemned by the Royal Colleges and led to Mackenzie's down-fall.⁷⁴ MacDonald too suffered trenchant opposition, as he had to "face incredibly stupid opposition from some of the most honoured ... even after [he] was invited to join the staff at King's College Hospital".⁷⁵

Joseph Toynbee (non-Harley Street), who was one of the founders of modern otology in Britain, gained professional recognition for his speciality when he was appointed as the first aural surgeon to St Mary's Hospital in 1852.⁷⁶ Though as early as the 1830s the surgeon George Pilcher was referred to as "a most successful aurist", based on the practice he established in Great George Street, Westminster. Pilcher later won the Fothergillian Prize for his "Treatise on the Structure and Pathology on the Ear" and ten years after he was elected FRCS in 1843, he established a practice in Harley Street.⁷⁷ The specialities of laryngology, rhinology and otology merged just before the First World War to become the recognised speciality, ear, nose and throat (ENT). Edward David Darelán Davis was amongst the pioneering practitioners. Davis, who qualified in both medicine and dentistry in 1903 was appointed to Charing Cross as a senior surgeon in 1912 just as ENT was emerging as a new speciality. He wrote numerous

⁷⁴ A. M. Cooke in *The History of the Royal College of Physicians of London*, Vol. 111, (Oxford, 1972), pp. 904-905.

⁷⁵ *Ibid.*

⁷⁶ Penelope Hunting, *The History of the Royal Society of Medicine* (London, 2002), p. 90

⁷⁷ Anon, 'Death of Mr. George Pilcher', *Lancet*, Nov. 10, 1855, p. 452.

articles on his speciality for the *BMJ* and *Lancet* and became a respected teacher of his subject at Charing Cross medical school.⁷⁸

Diseases of the Skin and Dermatology

Although some medical practitioners had specialised in diseases of the skin at the beginning of the nineteenth century, it was not until the late 1870s that dermatology emerged as a recognised speciality.⁷⁹ When the non-Harley Street physician Erasmus Wilson (1809-1884) was a student he asked the editor of the *Lancet*, Thomas Wakley whether he should stick to anatomy or take up dermatology. Wakley replied:

stick to skin. Read about skin, write about skin, speak nothing but skin, and that as publicly and as often as you can. Get your name so closely associated with skin that directly the name of Erasmus Wilson is mentioned in any drawing room, everybody present will begin to scratch.⁸⁰

Subsequently, Wilson became a celebrated skin specialist and amassed a fortune from his practice.

In the 1890s diseases of the skin were usually dealt with by general physicians or surgeons within a hospital. During this time the Harley Street physician, Arthur Whitfield was one of the few physicians who confined his career to dermatology, both in his hospital post and his private practice. When, the Royal Free Hospital created a dermatological department in the 1900s, Willmott H. Evans was put in charge, specialising in diseases of the skin, but he also continued with general surgical work.⁸¹ Whitfield entered dermatology in the late nineteenth century, when knowledge of bacteriology

⁷⁸ Anon, E. D. D. Davis', *BMJ*, Mar. 27, 1976, p. 76.

⁷⁹ For example, Dr Thomas Bateman published books on diseases of the skin in 1813, for more details see Hunting, *RSM*, p. 91.

⁸⁰ Kershaw, *Special Hospitals*, p. 30

⁸¹ Anon, 'Willmott H. Evans', *Lancet*, Sept. 17, 1938, p. 701.

was still in the early stages and he devoted a great deal of time to the subject; consequently, his discovery of finding fungus in ringworm of the toes was considered, "epoch-making".⁸² His endeavour proved fruitful when in he was appointed Professor of Dermatology at King's College (1906), became President of the Section of Dermatology at the RSM (1919-21) and was appointed President of the British Association of Dermatology (1927).

Henry Radcliffe Crocker, Tilbury and Thomas Fox, Henry MacCormac, James Startin and Malcolm Morris were among the Harley Street men who became well known dermatologists. Crocker who was described as "the foremost dermatologist of Britain" worked with and subsequently succeeded Tilbury Fox at UCH in the 1879.⁸³ He assiduously recorded a vast number of cases which were later published in his monograph, *Atlas of the Diseases of the Skin*, (1893). Although he was regarded as a specialist, his obituarist claimed his expertise lay in his ability to see dermatology from the point of view of general medicine.⁸⁴

Obstetrics and Gynaecology

Obstetrics was an enduring area of controversy in the nineteenth century since not only did general practitioners deliver babies as part of their role as the family doctor, but the man-midwife or accoucheur also had this responsibility. Obstetric physicians and surgeons largely confined themselves to the practice of obstetrics, they were not specialists in the strict sense, as they also dealt with general patients. Poor standards of

⁸² Anon, 'Arthur Whitfield', *BMJ*, Feb. 15, 1947, p. 274.

⁸³ Dr Pernet, 'Henry Radcliffe Crocker', *BMJ*, Sept. 11, 1909, p. 732.

⁸⁴ Anon, 'Henry Radcliffe Crocker', *BMJ*, Sept. 11, 1909, p. 729.

practice and inadequate training in midwifery stimulated the eminent Harley Street physician, Charles Mansfield Clarke, and members of the newly formed Obstetrical Society (1826) to campaign for a licence in the subject. Consequently, the Apothecaries Society demanded that students sitting the LSA should have proven midwifery experience. However, the Royal Colleges' apathetic response to exams in midwifery lay in the dual nature of the subject, which they defined as neither "pure physic" nor "pure surgery".⁸⁵ Clarke retorted that "Midwifery is a branch of physic, [or] a branch of surgery ... it is either medicine, or it is surgery, or it is both: it cannot be nothing".⁸⁶ It was not until the 1886 Medical Act that midwifery became a compulsory part of the medical curriculum.

Lying-in hospitals, such as Queen Charlotte's in Marylebone (1752) were established in London from the mid 1750s. By the late 1890s, 12 hospitals had been set up for maternity cases. St George's hospital was the first of the London teaching hospitals to create a specific lying-in ward in 1831. Previously women patients had been received in the general ward and in 1842, the first specialist hospital for women's diseases, (renamed the Hospital for Women in 1845) was opened in Red Lion Square by Protheroe Smith.

Robert Barnes, who beginning in the 1860s, sought to raise the profile of obstetrics through improved education and training, and increased staff

⁸⁵ See Ornella Moscucci, *The Science of Woman*, (Cambridge, 1990), for nineteenth century debates on obstetrics and gynaecology, see also Jean Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, (London, 1988).

⁸⁶ *Report from the Select Committee on Medical Education*, pp. 1834, Vol. XIII, evidence of Charles Clarke, Q. 4220, cited in Moscucci, *The Science of Woman*, p. 63.

appointments and representation on the GMC, became the first consultant obstetric physician to a teaching hospital in 1855. He was educated privately in Norwich and Bruges and at the age of 15 was apprenticed to a local medical practitioner; he later moved with his family to London. Barnes received his training at St George's Hospital, qualifying MRCS (1842) and spent a year in Paris before returning to London to set up practice in Mayfair in 1843. He qualified MD, London (1848) and FRCP (1857). He decided to specialise in obstetrics and was appointed Obstetric Physician to the London Hospital, then to St Thomas, before being elected Obstetric Physician at St George's in 1874. Five years later he moved to Harley Street.

Perhaps because Barnes was not a Fellow of the Royal College of Surgeons, (which would be the normal requirement for a senior member of the surgical staff) St. George's gave him a side room, away from the main body of the building. The medical historians Terry Gould, and David Uttley, commented that it was not known "whether this arrangement was dictated by a sense of decency, or whether, lacking a Fellowship, he was considered unfit to play in the major league".⁸⁷ Nevertheless, Barnes was rewarded for his skill in obstetric surgery by the Royal College of Surgeons in 1883 when they granted him an honorary FRCS: he was one of the few physicians in the period to be given this honour. He was a celebrated teacher of obstetrics who taught successively at the London, St Thomas's and St George's

⁸⁷ Terry Gould & David Uttley, *St George's Hospital and the Origin of its Ward Names* (London, 1997), p. 35.

Hospitals; the Robert Barnes laboratory at St George's Hospital medical school was posthumously named in his honour.⁸⁸

According to the Harley Street surgeon and consulting gynaecologist to Charing Cross Hospital, Cuthbert J. J. Lockyer, "the old scissors-and-tape obstetric physician began to encroach on the domain of the abdominal surgeon and to fight for the right to remove pelvic structures by the abdominal route".⁸⁹ The London teaching hospitals varied in their response to gynaecological surgery. At St George's, Barnes was, for example, permitted to undertake abdominal surgery, but this was a concession only and not part of the standard practice of the obstetric physician.⁹⁰ Even as late as 1912, no physician-accoucheur at Bart's was a full member of staff, nor was he permitted to undertake extensive gynaecological surgery, basically because they were not qualified FRCS.⁹¹ The Harley Street physician, Walter Spencer Anderson Griffith, was the first accoucheur in London to take the FRCS, which he did in 1881. When he became a full member of the Bart's staff in 1912, he was permitted to do Caesarean sections.⁹²

Thirteen medical practitioners in Harley Street specialised in gynaecology (four also practiced obstetrics), including the renowned surgeon, Victor Bonney who was described as "a leading, if not the foremost,

⁸⁸ Blomfield, *St. George's*, p. 76.

⁸⁹ Cuthbert J.J. Lockyer, 'Foreward', in *Historical Review of British Obstetrics and Gynaecology*, J.M. Munro Kerr, R.W. Johnstone and Miles H. Phillips, eds., (London, 1954), p. 355

⁹⁰ Moscucci, *The Science of Woman*, p. 167.

⁹¹ Green-Armytage, in *British Obstetrics*, p. 358.

⁹² *Ibid.*

gynaecologist of the first half of the twentieth century".⁹³ The 21 Harley Street men who specialised in obstetrics included the well-known, though later disgraced, physicians Isaac Baker Brown and Herbert Ritchie Spencer. Baker Brown, who was one of the founding governors and lecturers at St. Mary's Hospital, Paddington was appointed surgeon accoucheur in 1851 when the hospital received its first patients. He built large and successful surgical practice first in Harley Street in 1867 and from 1870 in Regent's Park, but his eagerness to perform clitoridectomies on girls as young as ten to cure them of their insanity resulted in his expulsion from the Obstetrical Society. The Society was not appalled by his method – other members had performed such operations – but Brown had coerced his patients and this was considered objectionable.⁹⁴ The career of Spencer, obstetric physician to UCH, was also discredited when he was accused of undertaking a vaginal examination on thirteen year old Eliza Armstrong, without her father's consent.⁹⁵

Children's Diseases and Paediatrics

John Bunnell Davis (a non-Harley Street man), who earned his MD from Montpellier in 1810, was one of the first medical practitioners to set up a dispensary for sick children.⁹⁶ The Universal Dispensary opened at 5 St

⁹³ Geoffrey Chamberlain, *Victor Bonney, the Gynaecological Surgeon of the Twentieth Century*, (London, 2000), p. vii.

⁹⁴ Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980*, (London, 1988), pp.75-77.

⁹⁵ Moscucci, *The Science of Woman*, footnote 66, p. 236.

⁹⁶ Thomas Coram, a retired sea-captain established the London Foundling Hospital, in the eighteenth century: the first hospital for children in England. See Elizabeth M. R. Lomax, *Small and Special: The Development of Hospitals for Children in Victorian Britain* (Wellcome, 1996). A dispensary for children in London opened on 24 April 1769 by George

Andrews' Hill, Doctor's Common in 1816, with the Dukes of Kent and Sussex as patrons.⁹⁷ The dispensary thrived until Davis died in 1824 and then languished for 15 years until the Harley Street physician, Charles West began to work there, where he remained for 10 years. During his time at the dispensary, he made vigorous attempts to convert it into a hospital with in-patient facilities, but was not successful. His efforts, however, were not in vain, as he went on to launch the Hospital for Sick Children, Great Ormond Street in 1852.⁹⁸ This was made possible because hospitals grew larger and gained prestige during the second half the nineteenth century; consequently, their outpatient departments began to absorb patients who had previously used a dispensary.⁹⁹

For the Victorians, the idea of establishing a children's hospital was contentious and opposed by many doctors because children were regarded as difficult patients who could not, after all, describe their symptoms and often required intensive nursing. The teaching hospitals varied in their response to junior patients; whereas the London Hospital opened a children's ward in 1840, children were still being mixed with adult patients until as late as 1923 at St Bartholomew's. Opposition was also mounted because it was assumed that a children's hospital would encourage poor parents to neglect their responsibilities.

Armstrong in Red Lion Square in Holborn, see Jules Kosky and Raymond J. Lunnon, *Great Ormond Street and the History of Medicine* (London, 1991), p. 4.

⁹⁷ Alfred White Franklin, 'Children's Hospitals' in Poynter, *Medical Education*, p. 108.

⁹⁸ For research into Great Ormond Street see, Andrea Tanner, Great Ormond Street Hospital Registers Project, *Lancet*, March 9, 2002, pp. 897-98.

⁹⁹ Irvine Loudon, 'The Origins and Growth of the Dispensary Movement in England' *Bulletin of the History of Medicine*, 55 (1981), pp. 322-42.

It was Edwin Chadwick's 1842 *Report on the Sanitary Condition of the Labouring Population of Great Britain*, depicting the high mortality rates of small children living in slum districts in manufacturing towns, that challenged the idea that the home was the best place for a sick child and indicated that there was a need for special hospitals for children. Following Chadwick's report, the establishment of charitable institutions for the deserving poor became an acceptable option and made it easier for Charles West to set up a hospital exclusively for children.

West was educated at a school run by his father and then apprenticed to a general practitioner in Amersham. He entered Bart's in 1833, but after two years went to Paris and then to Berlin where he earned his MD in 1837. He was considered to be an outstanding student at Bart's where he won the prize in Medicine in 1834, the first prize in Midwifery and the prize in Forensic Medicine, both in 1835.¹⁰⁰ He practised in Dublin initially and made midwifery his speciality; on his return to London in 1839 he joined the Infirmary for Children, Waterloo Bridge Road and was made physician there in 1842. He qualified FRCP in 1848, published his *Lectures on the Disease of Infancy and Childhood*, (which went through seven editions), and was appointed Lecturer in Midwifery at Bart's. He held the lectureship for 12 years, contributing to his reputation as an expert on the diseases of

¹⁰⁰ Anon, 'Charles West (8 August 1816-19 March 1898) MD, Berlin and FRCP, *Munk's Roll Vol IV* (1848). Felix S Besser, "Notes on Dr Charles West and his grave in Chislehurst (Kent)", *History of Medicine*, Spring 1975, Vol 6, no 1, pp. 47-50.

women.¹⁰¹ He also gave a full course of lectures on children's diseases in 1847 at the Middlesex Hospital.

In 1850 West spent a year abroad researching children's hospitals. On his return to London, with the help of Lord Ashley (later Lord Shaftesbury), he set about raising funds for a children's hospital. After securing the essential funding, West and his medical colleagues, William Jenner and Henry Bence-Jones, established the Hospital for Sick Children in the house of Richard Mead, Queen Anne's physician, in Great Ormond Street, which opened its door on St Valentine's Day 1852. There were very few patients in the first six weeks, and it was not until the novelist Charles Dickens published "Drooping Buds", the first description of the hospital, that it received some recognition. A week after its publication, Queen Victoria became the Patron and mothers started bringing their children to the hospital.¹⁰²

West was the hospital's senior physician for 23 years, resigned from its staff in 1875 and was subsequently appointed consulting physician. Samuel Gee, also of Harley Street, worked at Great Ormond Street whilst William Jenner resigned in 1862, one year after being appointed Physician-Extraordinary to the Queen. Jenner stayed on as consultant physician and also gave his time to the Victoria Hospital for Sick Children on its inception

¹⁰¹ Anon, 'Charles West', *Lancet*, Apr. 2, 1898, pp. 968-970.

¹⁰² Kosky and Lunnon, *Great Ormond Street*, pp. 6-7

in 1866.¹⁰³ By 1862, children with diseases of the bones and joints formed the largest single groups (10.7%) of inpatients at Great Ormond Street.

Following the establishment of Great Ormond Street, new paediatric hospitals opened in London and across Britain. Over a period of 40 years, from the 1850s, ten children's hospitals opened in London. Various Harley Street medical practitioners were attached to all of these hospitals, such as the Victoria Hospital for Sick Children, which was set up by the Harley Street surgeon George Cowell and Edward Ellis (non-Harley Street) in Tite Street, Chelsea in 1866. Other London children's hospitals included the East London Hospital for Children, Shadwell (1868), Cheyne Children's Hospital, Chelsea (1874), the Evelina Hospital (1869) and Paddington Green Children's Hospital (1883).

Britain did not have a chair in paediatrics until after the First World War. Whilst, King's College appointed George Frederick Still, a Harley Street physician who specialised in paediatrics, as an honorary professor of the disease of children in 1906, this was a non-stipendiary college position rather than a university professorship. Still who remained a physician at Great Ormond Street for 30 years, was later considered by many to be "the father of British clinical paediatrics". His work on juvenile rheumatoid arthritis subsequently led to the condition being known as "Still's disease".¹⁰⁴ Whilst it was advantageous for some specialists to adhere rigidly to one subject, it could also involve great financial risks. George Still

¹⁰³ Lomax, *Small and Special*, p. 158.

¹⁰⁴ Anon, 'Sir Frederick Still', *BMJ*, July 12, 1941, p. 69 and Miller-Keane, *Encyclopaedia & Dictionary of Medicine, Nursing & Allied Health*, (Pennsylvania, 1997), p. 1532.

realised it was possible to make a livelihood out of paediatrics only in London; his colleague in Edinburgh, Dr John Thomson, whom he regarded as the greatest of all paediatricians, could not make a living out of just treating children's diseases.¹⁰⁵

In 1890 there were about 50 convalescent homes for children in England and by 1900, the former entrenched notion that sick children would not thrive away from the home had been reversed. It was then thought that children required isolation within institutions dedicated specifically to their treatment. As Roger Cooter observed, there was a "gradual disappearance toward the end of the nineteenth century of hospitals for both women *and* children, and the subsequent rise of specialist institutions for each".¹⁰⁶ Although 7.46% ($n = 49$) of the cohort were on the staff of a children's hospital, only a handful including West, Still and Eric Pritchard, confined their practice to the diseases and treatment of children.¹⁰⁷ Perhaps as Elizabeth Lomax has suggested, medical practitioners realised that paediatrics did not hold out the promise of being a financially advantageous speciality.¹⁰⁸

Electro-therapeutics, Radiography and Neurology

Although medical practitioners had used electricity as a therapeutic aid on their patients since the eighteenth century, Guy's was the first teaching

¹⁰⁵ Newman, 'Specialism', p. 172.

¹⁰⁶ Roger Cooter, 'Introduction' in Roger Cooter (ed.) *In the Name of the Child: Health and Welfare 1880-1940* (London, 1992), pp. 1-18.

¹⁰⁷ Pritchard was a pioneer in child hygiene and was director of the Infants' Hospital, Vincent Square, Westminster, the largest children's hospital in Britain in the 1920s and 1930s. See, Anon, 'Eric Pritchard', *BMJ*, Nov. 6, 1943, pp. 591-92.

¹⁰⁸ Lomax, *Small and Special*, p. 9

hospital to publicly endorse the procedure and in 1836 designated an “electrifying room” for this purpose.¹⁰⁹ From the 1850s to the 1870s a number of hospitals specialising in electro-therapeutics were established in Mayfair and the Harley Street Area. The first and largest of these in the Victorian period, the National Hospital for Paralysed and Epileptic, was founded in Queen Square in 1859. In the 1860s the London Galvanic Hospital opened in Cavendish Square (1861) whilst the London Hospital for Epilepsy and Paralysis was established in Regent’s Park in 1866 (renamed the Hospital for Diseases of the Nervous System in 1888). The fourth institution dealing with epilepsy and nervous diseases in London, the West End Hospital for Nervous Diseases, which opened in 1878.

All the Harley Street men who specialised in diseases of the nervous system, were on the staff of one of these specialist hospitals. In the first quarter of the twentieth century, nine out of 14 senior physicians and surgeons in the National Hospital for Paralysed and Epileptic were Harley Street men, including the physicians, Howard Henry Tooth, Thomas Grainger Stewart, Samuel Alexander Kinnear Wilson and the surgeon, Donald John Armour.¹¹⁰ Other members of the medical staff, for example the physician, William Aldren Turner and the surgeon, Percy William George Sargent, had a special but not exclusive interest in nervous diseases.

One of the principal founders of the London Hospital for Epilepsy and Paralysis was Julius Althaus who graduated MD (1855) from the

¹⁰⁹ Iwan Rhys Morus, ‘The Measure of Man: Technologizing the Victorian Body’, *History of Science*, xxxvii, (Bucks, 1999), p. 4

¹¹⁰ Hewitt, *Year Book*, *passim*.

University of Berlin and later settled in London becoming MRCP in 1860.¹¹¹ Althaus first established a practice in Bryanston Street, Marylebone using electricity to treat nervous diseases before moving to Harley Street in 1884. A prolific writer on his specialty, his *Treatise on Medical Electricity* went through three editions (1859-1873). In the *Treatise* he cautioned that electricity was a “powerful agent”, which should only be used by a trained physician.¹¹² Wilhelm Roentgen’s subsequent discovery of X-rays in Würzburg in 1895 led to the establishment of X-ray departments in all the major hospitals in Britain by the First World War. Some of the earliest radiologists were Harley Street men, including Edward Warren Shenton, surgical radiographer at Guy’s who was described as a “pioneer radiologist”. He made numerous original contributions to the speciality including an instrument to detect metallic foreign bodies. His X-ray photographs brought him universal recognition as an expert in the medical profession. Other radiologists included Robert Knox, consultant radiologist to King’s, Hugh Walsham and Henry Lewis Jones, both consultant radiologists to Bart’s.

In the first quarter of the twentieth century Robert Knox was described as “the best-known British radiologist abroad” for his original work in radiology. Knox qualified MB/BS Edinburgh (1892), LRCP/MRCS (1893) and gained his MD Edinburgh in 1897. He began his career in radiology at the electrical department of the Great Northern Hospital before being appointed Director of the Electrical and Radio-Therapeutic

¹¹¹ Anon., ‘Julius Althaus, M.D.’, *British Medical Journal*, (June 16, 1900), p. 1508.

¹¹² Morus, ‘The Measure of Man’, pp. 6-7. J. Althaus, *A Treatise on Medical Electricity, Theoretical and Practical; and its use in the Treatment of Paralysis, Neuralgia, and other Diseases*, (London, 1859), p. 344.

Department at the Cancer Hospital, Fulham in 1912.¹¹³ The following year he became the senior radiologist at King's.

In 1891, when the Harley Street physician Henry Lewis Jones succeeded Dr. Steavenson (a non Harley Street practitioner), as medical officer in charge of the electrical department at Bart's, it was a simple one roomed structure, divided into a waiting room for patients, a room containing the electric bath, an operating room and a consulting room.¹¹⁴ By the 1900s, the department had expanded fourfold, excluding ancillary rooms that were used for X-rays.

Jones, considered the "founder of the English school of electro-therapy and its most influential teacher", introduced a number of innovative methods to Bart's in the treatment of paralysis, which included using mains electricity from the street lighting instead of the current from batteries. He also introduced the ionic (chemical) method and diathermy (high frequency electromagnetic currents) into Britain. Jones was actively involved with his speciality, writing numerous papers and articles on medical electricity. In addition to becoming President of the Electro-therapeutic Society (1903-1904) and editor of its *Transactions*, he was instrumental in the establishment of the electro-therapeutic section of the newly established RSM in 1907. The Harley Street surgeon, Chisholm Williams became the section's first London Secretary.

¹¹³ Lyle, *King's*, p. 401.

¹¹⁴ Anon, 'Henry Lewis Jones', *BMJ*, April, 17, 1915, pp. 700-701.

Until the nineteenth century the study of diseases of the nervous system (later neurology) was viewed as part of internal medicine. It was not until the second half of the nineteenth century with developments in neuro-anatomy and physiology that neurology became a specialist subject.¹¹⁵ The Harley Street physician, Samuel Alexander Kinnear Wilson, was one of the most renowned international figures in neurological medicine.¹¹⁶ He was educated at Edinburgh and qualified MB 1902 and BSc. a year later. He worked for a short time as a house physician at the Royal Edinburgh Infirmary before going to Paris where he worked with Pierre Marie (1853-1940), a pupil and disciple of Jean Martin Charcot (1825-1893), whose neurological clinic was internationally recognized. In 1904, Kinnear returned to England where he got a post as house physician at the National Hospital, Queen Square, eight years later he was appointed assistant physician to Westminster Hospital and became Dean of its medical school two years later. In 1919 he moved to King's College Hospital and was made junior neurologist and lecturer in neurology to King's College Hospital (1919).

In 1928, following the retirement of another Harley Street physician William Aldren Turner, Wilson was appointed senior neurologist at King's. Wilson retained his loyalty to the National Hospital for most of his career, working his way up the ranks of resident medical officer, registrar, to an appointment as physician to in-patients (1925). He became a long standing

¹¹⁵ Erwin Ackerknecht, *A Short History of Medicine*, (New York, 1982), p. 202.

¹¹⁶ Anon, 'S.A. Kinnear Wilson', *Lancet*, May 22, 1937, pp. 1253-54.

friend and follower of one of the founders of British neurology, John Hughlings Jackson (1834-1911).

Wilson was among the Harley Street physicians who also had a disease named after them. In 1912, he published his discovery of inherited progressive disease in the journal *Brain*, which linked cirrhosis of the liver and degenerative changes in the brain with the body's inability to metabolise copper, which became known as *Wilson's disease*. He is also well known for his work on various disorders of muscle tone and hysteria. Wilson was a prolific writer on his speciality which included such monographs as *Modern Views on Neurology* (1928). He delivered the Croonian lectures at the RCP (1925) and the Morison lectures at the RCP, Edinburgh (1930) on his subject. He was described as an able teacher, whose lectures at the National Hospital were attended by "throngs of students from all over the world".¹¹⁷

One of the frequently expressed objections to specialism was described by the Harley Street consulting physician to the National Hospital, Queen Square and to Charing Cross Hospital, Sir Gordon Holmes, who said of Queen Square that

one of the risks to which the new foundations was exposed was the hostility of the medical profession to the establishment of special hospitals, as at the time several institutions had sprung up in London, sponsored by quack or irregular practitioners or devoted to special, and usually unorthodox method of treatment.¹¹⁸

¹¹⁷ *Ibid.*

¹¹⁸ Gordon Holmes, *National Hospital Queen Square*, (London, 1954), p. 12.

Holmes was also a Harley Street eponymist who gave his name to the Holmes-Adie syndrome (which symptoms include a dilated pupil in cerebellar disease). He was one of the leading specialists in neurological medicine in the early twentieth century. Other Harley Street men who specialised in diseases of the nervous system included the physicians Henry Head, Frederick Stephen Palmer, Frederick Eustace Batten, James Purves Stewart and the surgeons Edwin Lancelot Ash and Donald John Armour.

Pathology

From the first quarter of the nineteenth century, pathology was an intrinsic part of the medical curriculum at the London teaching hospitals. Whilst Guy's Hospital, for example, taught the subject from the opening of its medical school in 1826, according to W.D. Foster, there were no *professional* pathologists in Britain at the time. It was not until the 1840s that doctors who worked as demonstrators in morbid anatomy and who commonly acted as museum curators in charge of pathological specimens were appointed by the London teaching hospitals. Though these were junior posts, this was nevertheless a useful stepping stone to the coveted consultant appointments at the hospital.

Charles Alfred Ballance, an aural surgeon, was amongst the leading experts in the practise of pathology. A year after his arrival in Harley Street in 1884, Ballance was described as the driving force in the development of diagnostic bacteriology at St. Thomas's Hospital.¹¹⁹ Another prominent figure in the field was Henry Trentham Butlin, who was described as "one of

¹¹⁹ Lomax, *Small and Special*, p. 7.

the most distinguished members of the profession".¹²⁰ He had planned to become a general practitioner in Kent but changed his mind after acting as James Paget's house surgeon, and decided instead to remain in London to develop a consulting practice. Butlin was a surgeon and pathologist and later the first Dean of the Medical Faculty of London University. In his role as President of the Pathological Society, he delivered the address at its jubilee in 1896.¹²¹ Butlin was a member of the Council of the RCS from 1895-1912 and held the office of President from 1910-1911.

William Watson Cheyne, considered a pioneer in antiseptic surgery, was Joseph Lister's first House surgeon at King's College Hospital in 1877.¹²² He became interested in surgical pathology to such an extent that "he nearly ruined himself as a surgeon by becoming too well known as a pathologist".¹²³ In addition to his role as President of the Pathological Society, Cheyne also served as President of the RCS (1914-1917), the Harveian Society (1902) and the Medical Society of London (1912).

Some Other Harley Street Specialists

When Hugh Morrison Davies specialised as a thoracic surgeon in London in 1910, it was then a completely new field of surgery in Britain: many believed that diseases of the lungs and chest could not be surgically treated. Davies was educated at St George's Ascot, Winchester and then Trinity College, Cambridge where he qualified BS (1904). After graduating, he

¹²⁰ Anon, 'Sir Henry Trentham Butlin', *BMJ*, Feb. 3, 1912, p. 277

¹²¹ *Ibid.*

¹²² Zachary Cope, *The History of The Royal College of Surgeons of England* (London, 1959), p. 313.

¹²³ Lyle, *King's*, p. 339.

trained at UCH where he met Wilfred Trotter with whom he would share a house in Harley Street in 1912. Davies became FRCS in 1906 and later qualified MS (1907) and MD (1908) at his Alma Mater. Following his MD, he spent a month in Germany to learn the language and when he returned to London in 1909, he accepted the position of Assistant Surgeon at UCH. His appointment provoked strong opposition amongst the surgical staff at the hospital as Davies's surgical methods were considered unorthodox; the junior physician declared that Davies had "no right to be a surgeon at this hospital. I have done my best to oppose you. It is a disgrace that they accepted you".¹²⁴

Another Harley Street medical practitioner, Arthur Edward James Barker, who introduced spinal anaesthesia into Britain, helped Davies with a number of his patients at UCH. Davies decided to study the X-rays of patients with diseases of the chest, but he faced continued opposition amongst his colleagues at UCH. Davies later recalled:

but I went on to fight the surgeons and physicians in the hospitals! I knew that X-rays were going to tell us things we did not know before. But they didn't believe me! There was a big row. My fellow physicians thought I was crazy, but I felt it was essential.¹²⁵

In 1912, Davies performed the first thoracic operation in Britain in which he removed the ribs of a female patient so that her lungs collapsed, allowing the diseased tissue to repair itself.¹²⁶ The patient recovered well and lived for a further 27 years.

¹²⁴ Kathleen Webb, Hugh *Morrison Davies*, Pioneer Thoracic Surgeon, 1879-1965, (Wales, 1998), p. 3.

¹²⁵ Webb, *Morrison Davies*, p. 17.

¹²⁶ *Ibid.*, p. 18.

Described as a pioneer in mental illness, Francis Warner, physician to the London Hospital, was one of the first to embark on clinical research into the physical and mental defects of children.¹²⁷ In 1890, he published his research on 50,000 children from 106 schools in London, which revealed large variations in the development of children from different locations and ethnic backgrounds.¹²⁸ Harley Street specialists in mental diseases included the physicians Thomas Claye Shaw and John Langdon Down. Shaw gained his experience at Colney Hatch Asylum before becoming Medical Director of Banstead County Asylum, Surrey. He was a recognised authority in mental disease and a campaigner for the creation of mental clinics in out-patients departments of general hospitals.¹²⁹ Langdon Down, identified the abnormalities associated with mongolism in 1866, (re-designated Down's syndrome in 1961).¹³⁰ The results of Langdon Down's research was later published as *Mental Affections* (1887).¹³¹

Urology, was established as a specialist subject in Britain through the work of the Wimpole Street surgeon, Sir Henry Thompson. Known as "the father of British urology", Thompson first delivered a paper on the prostate gland at the RSM in 1857.¹³² The Harley street surgeon, Cyril Arthur

¹²⁷ Anon, 'Francis Warner', *BMJ*, Nov. 6, 1926, p. 857.

¹²⁸ Anon, 'Warner', pp. 857 and 1022.

¹²⁹ Lyle, *King's*, p. 159.

¹³⁰ Davis Coakley, *Irish Masters of Medicine*, (Dublin, 1992), p. 259. Other eponymists included George Busk, a skilful anatomist who discovered large parasites in the duodenal lumen of an East Indian seaman at post-mortem examination. The organism was subsequently named *Distoma buski* by the zoologist E. Ray Lankester. See Cook, Gordon, "George Busk FRS, (1807-1886), Nineteenth Century Polymath: Surgeon, Parasitologist, Zoologist and Palaeontologist", *Journal of Medical Biography*, Vol. 5, 2, (May 1997), pp. 88-101.

¹³¹ John Langdon Down, *Mental Affections*, (London, 1887).

¹³² Hunting, *RSM*, p. 143.

Rankin Nitch was also regarded as a pioneer in the development of urology in England. He was responsible for starting urology as a speciality at St. Thomas's in the 1920s by establishing an outpatient department for those with diseases of the urinary tract .¹³³

Orthopaedics emerged as a special branch of surgery in the nineteenth century when medical practitioners began to focus on the correction of deformities of the skeletal system in their patients, particularly children.¹³⁴ A number of advances, such as quick-drying plaster of Paris, and iron arm or leg splints devised by Hugh Owen Thomas, of Liverpool (1834-91) greatly assisted patient recovery. It was not, however, until after the Great War that orthopaedics was generally recognised as a speciality, acquiring academic support as medical schools developed orthopaedic departments and hospitals introduced special surgical procedures. One of the leading orthopaedic surgeons in Britain, Sir Thomas Arthur Harold Fairbank, joined the staff of the Charing Cross Hospital, as an orthopaedic surgeon in 1904, a year before he arrived in Harley Street.¹³⁵ Charing Cross was the first London hospital to elect a surgeon exclusively for orthopaedic work. When he was appointed to the staff of Great Ormond Street he worked as a general surgeon. It was not until after the First World War that Fairbank was asked to run the newly established orthopaedic department at King's College Hospital.

¹³³ Anon, 'Cyril Arthur Rankin Nitch', *Lancet*, Sep. 27, 1969, p. 702.

¹³⁴ For a history of orthopaedics see, Roger Cooter, *Surgery and Society in Peace and War*, (London, 1993).

¹³⁵ Anon, 'Sir Thomas Fairbank', *BMJ*, March 11, 1961, pp. 751-52.

Teaching Hospitals and Specialist Departments

The number of special departments in London teaching hospitals rose from 23 in 1855 to 52 in 1875, which Peterson argued was as much to do with the monetary ambitions of Victorian practitioners as with philanthropic motives or the desire to serve science.¹³⁶ In the nineteenth century, however, teaching hospitals remained formal institutions with a high degree of protocol. Medical and surgical staff at London teaching hospitals, such as St Mary's, were expected to resign if they accepted a position at a specialist hospital, particularly if that hospital dealt with cases normally part of a teaching hospital's remit. The Harley Street surgeon, Walter Coulson resigned his position at St Mary's in 1865 when he was offered the position of senior surgeon to St. Peter's Hospital for the Stone. He was unsuccessful when he later tried to be re-elected at St Mary's, probably because as Elsbeth Heaman argued, "into the twentieth century St Mary's was a bulwark of generalism".¹³⁷ Similarly, newly appointed staff at teaching hospitals were normally expected to relinquish previous appointments at specialist hospitals. However, approximately half (47.62%, $n = 10$) of those holding hospital posts at St Mary's had other staff positions, and this became increasingly more prevalent from the time of the First World War.

In the mid-nineteenth century, St Mary's relaxed its stance on specialism, in areas where they would not usually accept in-patients such as children, skin or venereal diseases, maternity or fever cases and the

¹³⁶ Peterson, *Medical Profession*, pp. 248-249.

¹³⁷ Heaman, *St Mary's*, p. 43.

insane.¹³⁸ The paediatrician, Reginald Henry Miller, was, for example, a paediatric physician to both St Mary's and Paddington Green Children's Hospital when he arrived in Harley Street in 1914.¹³⁹ Likewise, William John Gow, Obstetric Surgeon to St Mary's, was concurrently consulting gynaecologist to the Royal Waterloo Hospital for Children and Women and consulting physician to Queen Charlotte's Lying-in Hospital. A similar precedent was discernable at St George's Hospital, during the nineteenth century, only experts in obstetrics, ophthalmology or childhood diseases, had additional hospital posts outside St George's.

To counter the threat from specialist hospitals, teaching hospitals established their own special departments. The change of pace varied greatly. King's College Hospital, for example, did not adopt specialism comprehensively until the 1930s when it had profited from the work of such Harley Street men as Sir George Still in paediatrics, Harold Arthur Thomas Fairbank in orthopaedics and Samuel Kinnear Wilson in neurology.¹⁴⁰ In 1831, Guy's was the first London teaching hospital to establish an ophthalmic department.¹⁴¹ St Mary's opened an out-patient clinic in 1867, specialising in skin and throat diseases. However, it was not until 1882 that Malcolm Morris of Harley Street was appointed as the hospital's first dermatologist.¹⁴² After Morris's medical training at St. Mary's Hospital in 1870, he returned to Yorkshire to work in general practice. Nevertheless,

¹³⁸ Peterson, *Medical Profession*, p. 104.

¹³⁹ Heaman, *St Mary's*, p. 168.

¹⁴⁰ Newman, 'Specialism', p. 178.

¹⁴¹ Cameron, *Guy's*, p. 191.

¹⁴² Anon, 'Sir Malcolm Morris', *BMJ*, March 1, 1924, pp. 407-409 and Cameron, *Guy's*, p. 107.

his interest in skin diseases encouraged him to accept an appointment to the staff at the Hospital of Diseases of the Skin, Blackfriars and he "lost no time in identifying himself with the speciality in which he was later to become a leader."¹⁴³ He was the first surgeon to be elected to the skin department at St Mary's, and he continued his work as a surgeon at the Seamen's Hospital, Greenwich.¹⁴⁴

Specialisation was further advanced at St Mary's when the dean of its medical school, the Harley Street aural surgeon, George Purdey Field, persuaded the governors to build new special wards by extending the hospital onto Praed Street. By the end of the 1880s ophthalmic, aural, dental and dermatological patients could separately be accommodated.¹⁴⁵

Of the senior staff of St George's Hospital only 10 out of 98 (10%) were Harley Street men.¹⁴⁶ Only four of these, Humphry Davy Rolleston, Robert Barnes, Robert Brundell Carter and Harold Barr Grimsdale, became consultants to St George's.¹⁴⁷ Rolleston worked his way through the ranks of assistant physician (1893-1898), physician (1898-1918) and was finally appointed consulting physician in December 1918. Until the 1890s, specialists at St George's dealt exclusively with diseases of women (obstetrics and gynaecology) and diseases of the eye, all other conditions were dealt with by the hospital's general surgeons and physicians. Carter was appointed the hospital's first ophthalmic registrar and in 1893 was

¹⁴³ *Ibid.*

¹⁴⁴ Anon, 'Morris', *BMJ*, pp. 407-409

¹⁴⁵ Heaman, *St Mary's*, p. 108.

¹⁴⁶ Compiled from a list of senior and junior staff members between 1733 and 1933 in Blomfield, *St. George's*, pp. Appendix II and III, pp. 110-113.

¹⁴⁷ *Ibid.*

elected first consulting surgeon to St George's having served as ophthalmic surgeon (1870-1893). Arthur Gamgee (1887-1889) was elected assistant physician whilst Francis George Penrose (1889-1897) and Frederick Golla (1920-1923) became physicians. Apart from the obstetric and ophthalmic wards, none of the cohort worked as surgeons or assistant surgeons to the hospital.

Hospital Appointments held by the 1845, 1880 and 1914 Groups

The hospital appointments held by the Harley Street men and those from the Harley Street Area and a sample from Greater London were examined for the years 1845, 1880 and 1914. Results are shown in Tables 4. 3, 4. 4 and 4. 5 Appendix D, respectively. Although this comparative study was based on a small number of medical practitioners in 1845 it was found that Harley Street (12.50%, $n = 1$) and the Harley Street Area (52.62%, $n = 10$) had more consulting and senior physicians and surgeons from the London teaching hospitals than Greater London (5.94%, $n = 6$). The data also confirm that 50 per cent of the Harley Street cohort and 31.58 per cent from the Harley Street Area did not hold a staff post in 1845 (which may be due to omissions in the *Medical Directory* as discussed in Chapter One), whilst the majority, 78.22 per cent in Greater London, did not have a staff position in the period. The numbers in Harley Street, however, were too small to make decisive judgements on the professional profile of these groups, consequently the years 1880 and 1914 were also analysed.

When Peterson evaluated status in London teaching hospitals in 1878, she used the criteria of rank and suggested that senior status in a

hospital could be used as an index of success. From this basis she then argued that

for most of the nineteenth century, the inner circle of elites numbered no more than 180 — five percent of all London practitioners and just over one percent of medical practitioners in England and Wales.¹⁴⁸

An examination of all the medical practitioners in Harley Street and the Harley Street Area just two years later, indicates that a large proportion of practitioners in Harley Street held senior positions at the London teaching hospitals. In 1880 there were 26 men in Harley Street, in addition to the 45 from the Harley Street Area, which represents almost 40 per cent of the inner circle.

In contrast to Greater London in 1880 (38.18%, $n = 126$) few Harley Street men (10.79%, $n = 30$), or those from the Harley Street Area (10.53%, $n = 42$) relinquished their hospital posts when established in private practice. Edwin Lancelot Ash, a specialist in the prevention of nervous disorders and physician to the Kensington General Hospital (previously house physician at St Mary's Hospital) was one of the few Harley Street men who, resigned their hospital appointments owing to pressure of private practice.¹⁴⁹

In 1914, over a third, (37.05 per cent, $n = 103$) of those registered in Harley Street were either consultants or held a senior posts at one of the London teaching hospitals, whilst slightly fewer (30.58 per cent, $n = 122$) registered in the Harley Street Area held these positions. This contrasts with the tiny proportion of medical practitioners in Greater London; only

¹⁴⁸ Peterson, *Medical Profession*, p. 137.

¹⁴⁹ *The Medical Who's Who*, 1913, p. 18.

2.12 per cent ($n = 7$), who held similar appointments. Thus, Harley Street had fifteen times as many prestigious consulting or senior physicians and surgeons as Greater London in general.

Three quarters of Harley Street men (73.74%, $n = 205$) held a consulting or senior staff post in a teaching or a general hospital, in contrast to two thirds in the Harley Street Area (62.66% , $n = 250$) and (10%, $n = 33$) in Greater London. The majority of those in Greater London (73.94%, $n = 244$) held no staff post at a hospital at the time of the sample in 1914, (though 35.76%, $n = 118$, had held one previously) the opposite was true for Harley Street where only 16.55 % ($n = 46$) did not hold a current staff appointment (10.79%, $n = 30$ had a former hospital post) whilst 22.56% ($n = 90$) from the Harley Street Area, did not hold a current staff appointment at a hospital (10.53%, $n = 42$ held one previously). Thus, eight times as many of the medical practitioners in Greater London (38.18%, $n = 126$) held no hospital appointment at all by 1914 as opposed to those from Harley Street (5.76%, $n = 16$). Thus, it may be argued that a hospital appointment was a *sine qua non* in creating a successful Harley Street practice.

Multiple hospital appointments became increasingly common over the period, which was a reflection of the changing nature of the medical profession and the growth of special hospitals and professionalisation in medicine. In 1845 Henry Hancock was the only Harley Street man who held more than one hospital post (at Charing Cross and the Royal Westminster Ophthalmic Hospital). By 1880, the number with more than one hospital appointment, had increased to 36.84 % ($n = 21$) in Harley Street; the

majority held either two or three positions. The distinguished obstetrician Robert Barnes, consulting physician to St George's Hospital, was an exception, since he held 6 other hospital posts in diseases of women and children. By 1914, more than half (56.47%, $n = 157$) the Harley Street group had multiple posts. The majority held two posts (32%, $n = 89$), followed by three posts (14.03%, $n = 39$), four posts (5.76%, $n = 16$), five (3.60%, $n = 10$) and finally six (1.08%, $n = 3$). Just under half (48.62%, $n = 194$) the men in the Harley Street Area held multiple hospital appointments. The majority held two posts (28.32%, $n = 113$), followed by three posts (14.54%, $n = 58$), four posts (4.76%, $n = 19$), five (1%, $n = 4$). Only a minority in Greater London held more than one hospital position (6.66%, $n = 22$), most of these held two posts (5.45%, $n = 18$), whilst two men held three posts, two held four posts and only one, G. D. Robinson an obstetric physician registered at Portman Square held six hospital appointments. Thus, over eight times as many Harley Street men and seven times as many from the Harley Street Area held multiple hospitals posts than those from Greater London.

Teaching Appointments

Half the cohort (49.77%, $n = 327$) lectured at some point in their careers, of these, approximately a fifth ($n = 71$) retired from their teaching post before they arrived in Harley Street. Whilst others, such as George Harley, were forced by the pressure of private practice to resign their teaching posts. The only British medical college to include physiology as a recognised subject on the medical curriculum in 1845 was University College London, though the

subject was at that time theoretical rather than clinical.¹⁵⁰ A decade later George Harley was invited by UCL to lecture in Practical Physiology and subsequently became the first Professor of Practical Physiology in England.¹⁵¹ However, his Harley Street practice flourished to such a degree that he was forced to relinquish his lectureship in 1869.

A proportion of the cohort lectured at Bart's ($n = 27$), and the Middlesex ($n = 27$), the most prosperous of the London medical schools. Teaching posts at UCH ($n = 26$) and the London ($n = 24$) were the next popular choices, whilst St George's ($n = 11$) and the Royal Free ($n = 6$) were the least in demand. Overall, the single most common teaching post (15 per cent) amongst the cohort was demonstrator of anatomy or assistant demonstrator. Demonstratorships were junior positions brought in by the London teaching hospitals from 1840 onwards, whilst the assistant positions appeared towards the end of the nineteenth century.¹⁵²

Apart from these junior positions there was no preponderance of any particular subject taught by the group; they ranged from professor or lecturer in general medicine or surgery and in many specialists subjects. The vast majority of Harley Street medical practitioners held one lecture post at a time, only three individuals had multiple posts. Charles Wilberforce Daniels held the greatest number of teaching posts, as he

¹⁵⁰ Sir Edward Sharpey-Schafer, F.R.S. *History of the Physiological Society during its first fifty years: 1876–1926* (London, 1927), pp. 1–2.

¹⁵¹ Mrs Alec. Tweedie, (ed.) *George Harley F.R.S. or the Life of a London Physician*, (London, 1899), pp. 120–21.

¹⁵² Peterson, *Medical Profession*, p. 160.

lectured on tropical diseases concurrently at the London Hospital, the LSMW and the London School of Tropical Medicine.

Teaching posts held by those in Harley Street, the Harley Street Area and a sample from Greater London were examined for the years 1845, 1880 and 1914 and these are shown in Table 4. 6, Appendix D. The results showed that in 1914, twice as many in Harley Street ($n = 128$, 46.04%) had teaching appointments than those in the Harley Street Area and fifteen times more teaching appointments than practitioners in Greater London.

Inventors

A number of the earliest specialists in the Victorian period, such as the Harley Street's Arthur Edward James Barker, Edward Canny Ryall, Morrell Mackenzie, James Coles, Henry Hancock, Hugh Morriston Davies, George Buckston Browne and Victor Bonney designed instruments to assist them in their practice. Baker, who was one of the original authorities on abdominal surgery, invented a number of surgical instruments for his speciality, one such appliance was the "surgical sewing machine", which eliminated the need to re-thread his needle and was designed to be used on the abdomen, but could equally be used on other parts of the body.¹⁵³

Ryall, who was described as a "pioneer in genito-urinary work", developed his speciality in the 1920s at the All Saints Hospital, Buxton Road, London. Among the many instruments developed by Ryall in the 1920s, his prototypical cystoscopes and endoscopes were still in general use two decades later. James Coles invented the orthopaedic sofa for the

¹⁵³ Anon, 'Arthur Edward James Baker', *Lancet*, Apr. 22, 1916, p.883

treatment of spinal afflictions, and Henry Hancock created "an apparatus for the treatment of fracture of the clavicle".¹⁵⁴ Although Sir Morell Mackenzie devised many instruments for his laryngological practice, according to his obituarist he played down his achievement as he felt "it was only second rate men who would think it worth while to claim credit for mechanical ingenuity of that kind."¹⁵⁵

Conclusion

The rapid proliferation of special hospitals at the end of the nineteenth century exemplified the changing nature of medicine in Victorian London. Such Harley Street men as Charles West, George Cowell, James Startin, Morrell Mackenzie, Julius Althaus and Robert Brudenell Carter were at the forefront of establishing special hospitals for children, dermatology, throat diseases, electro-therapeutics and ophthalmology respectively. Many of these hospitals were set up in response to the development of technical apparatus that allowed for the creation of sub-disciplines such as the ophthalmoscope, laryngoscope and X-rays and new techniques such as the pioneering surgical work of George Critchett, Morell Mackenzie, Hugh Morriston Davies and James Mackenzie, which advanced specialist areas. In such a highly competitive job market for medical practitioners during the mid-to late-nineteenth century, when work was scarce even for those who were highly qualified, it may be seen that the establishment of new specialised branches of medicine not only led to the professionalisation of

¹⁵⁴ *Medical Directory*, 1852, p. 23 and *Medical Directory*, 1845, p.71

¹⁵⁵ Anon, 'Sir Morell Mackenzie', *BMJ*, Feb. 13, 1892, p. 363.

these fields of study, but this also meant that many Harley Street men had, *ipso facto*, created jobs for themselves.

Yet specialists could not claim unanimous support from the medical profession. Scathing attacks appeared in the *Lancet* and to a lesser extent the *BMJ*, ascribing egocentric motives to doctors in founding special hospitals. In an editorial in the *BMJ* in 1860, the decline in contributions to charitable institutions was attributed to the rise in subscriptions to special hospitals, particularly those established by:

an energetic surgeon who makes up his mind to step to fame and fortune by means of bricks and mortar, thinks up a striking speciality, such as a 'Dispensary for the Treatment of Inverted Eyelashes', takes a house in a side street, persuades a goodly sprinkle of the aristocracy, in an incredibly short time, to pledge support, produces accounts audited by dilettanti and with the help of careful got up statistics expands the Dispensary into a hospital, converts the old woman who used to sweep the Dispensary into a proud hall porter and a small table in a back room into a board room.¹⁵⁶

Despite scientific advances in pathology, bacteriology and physiology, and the crucial developments in surgery of anaesthesia and asepsis in the nineteenth century, their therapeutic effectiveness did not have an immediate effect on the lives of their patients. Nonetheless, it was often the public who embraced such advances in science, medicine and surgery, especially the new medical specialities, which, no doubt, enhanced the reputation of the medical profession. Their attitude quite likely helped to produce an increased demand for the new specialities that were emerging in Britain from the 1850s onwards.

With over half of all Harley Street men claiming an interest or expertise in different areas of medicine or surgery, they not only played a

¹⁵⁶ Anon, 'Special Hospitals', *BMJ*, 1860, p. 458, cited in Newman, 'Specialism', p. 174.

pivotal role in the creation of new areas of expertise, but their efforts to establish hospitals and societies for these specialities facilitated the professionalisation of medicine during this time. In the 1930s, Rolleston remarked that the popularity of Harley Street may be explained “by the lure of the phrase ‘the Harley Street Specialist’” and he surmised that “during the last century ... one of the most important events [in medicine] has been the complete recognition of legitimate specialism”.¹⁵⁷ Such men as Sir George Frederick Still (paediatrics), Morell Mackenzie (laryngology), Edmund Alexander Parkes (rare diseases), Frederick Parkes Weber (rare diseases), Horace Bengé Dobell (diseases of the chest), Edward Collet Hort (bacteriology), George and Anderson Critchett, (ophthalmology) George and Arnold Lawson (ophthalmology), Sir John Tweedy (ophthalmology), Willmott H. Evans (dermatology), Charles Mansfield Clarke (obstetrics), Victor Bonney, (gynaecology), Robert Barnes (obstetrics), Henry Lewis Jones (radiology), Robert Knox (radiology), Samuel Alexander Kinnear Wilson (neurology), John Langdon Down (mental diseases) and William Watson Cheyne (antiseptic surgery) who pioneered new areas of medicine and improved other areas of expertise, were foremost amongst those medical practitioners who made specialisation of medicine and surgery a possibility.

The comparative analysis of Harley Street, the Harley Street Area and Greater London proves that Harley Street and to a lesser degree the Harley Street Area were unequivocally the nucleus of consulting and

¹⁵⁷ Humphry Rolleston, ‘The changes in the Medical Profession and Advance in Medicine during the Last 50 Years’, *BMJ*, 23 July, 1932, pp. 129-130.

specialist practice before the First World War. The next Chapter discusses the cohort's professional development *vis-à-vis* their contribution and membership of medical societies.

CHAPTER 5

Professional Advancement and the Transmission of Medical Knowledge — Public Lectures and Society Memberships

The dissemination of knowledge via lectures, societies' meetings and through publications is a hallmark of virtually all areas of medicine; such activities in the late nineteenth and early twentieth centuries often signalled the growth of professionalisation and specialisation of medicine. Orations and lectures ranged from the very prestigious to the more mundane. The most illustrious was the Harveian Oration, which adopted many Victorian ideas that were used in the creation of traditions through combining the adoption of older, established practices along with the creation of new rituals.¹ Such was the prestige of the Harveian Oration that the editors of the *Times*, *Lancet*, *BMJ*, *Daily Telegraph* and the Press Association were invited to this event.²

Despite the role that orations and lectures played amongst medical professionals in Victorian London, historians of medicine have paid little attention to the full range of these lectures. There has been no critical analysis of the large number of medically based orations and lectures during this time. Moreover, whilst there was an extensive range of medical

¹ For a discussion of the creation of tradition in the Victorian period see, Eric Hobsbawm and Terence Ranger (eds.), *The Invention of Tradition*, (Cambridge, 1983).

² "List of those to whom cards were sent [for the Harveian Oration]" 1902, Letters and papers in the Library of the RCP, 1024/17.

societies, many of which were created during the latter part of the 19th century, these too have not been subject to any systematic analysis by historians of medicine. Hence, the first part of this chapter will discuss Harley Street orators and these will be placed in the broader context of the Victorian reinvention of traditions. The range of the medical societies to which the Harley Street group belonged to and the aims of these societies will be assessed in the second part of this chapter. It will be further established which high-ranking positions various Harley Street practitioners held within these medical societies.

Rituals and Public Lectures

The nineteenth century was a period of rapid transformations through the many developments in technology and science that affected society, the monarch, political institutions and the rising professional classes. At a social level the most fundamental changes were due to faster modes of transportation and quicker forms of communication than had previously been feasible. Steam power made steamboats and steam trains possible and the first commercial railway service began in 1830: seven years later the telegraph was first used on English railroads. By 1876, the telephone had opened up faster methods of communication whilst the typewriter, phonograph, microphone, radio waves, X-rays and gas lighting irrevocably changed British society. The Victorians, who regarded invention as a way of solving problems, responded to these dramatic and disorientating developments by inventing new traditions and creating rituals for various

social and political reasons. As David Cannadine observed, these new traditions gave an impression of stability in periods of domestic change and of continuity and comfort in times of international tension and decline.³ Eric Hobsbawm regarded the idea of inventing traditions as a process of formalisation and ritualisation, characterised by reference to the past, if only by imposing repetitions.⁴ In a renaissance of the baroque tradition, state and church often came together, which was best exemplified in the Harveian Oration and Sermon.

Compelling rituals grew up around various events and occasions, especially in clubs and societies where orations and lectures formed a part of the organisation. For some events, this involved the attendance of government officials, festivals, dinners, toasts and the Oration itself, which were all part of this complex process. Ideas were often borrowed from medieval times such as the wearing of gowns to attend an oration. For example, Lord Dawson of Penn wore a robe as President of the RCP on the occasion of his Harveian Oration in 1936, modelled after the gown worn by William Harvey (1578 – 1657) when he received his medical degree from the University of Padua in 1602.⁵ Upholding this new tradition, the RCP mandated in 1827 that Fellows of the Oration should wear robes and a penalty of £2 was fixed for non-compliance. (Though by 1923 the wearing of robes was discontinued under “the mistaken belief that it was the cause of

³ David Cannadine, ‘The Context, Performance and Meaning of Ritual: The British Monarchy and the ‘Invention of Tradition’, c. 1820-1977” in Eric Hobsbawm and Terence Ranger (eds.), *The Invention of Tradition*, (Cambridge, 1983), pp. 101-164.

⁴ Eric Hobsbawm, ‘Introduction: Inventing Traditions’ in Hobsbawm and Ranger, *Invention of Tradition*, p. 4.

⁵ Hunting, *RSM*, plate 34.

non-attendance of younger Fellows".⁶) Decorations were worn at the Harveian dinner when any one of the following attended: a member of the Royal Family, a Knight of the Garter or the Lord Mayor of London.⁷

Whilst the first Harveian Oration in 1657 was delivered in Latin, by 1865 it could be delivered in English. Perhaps this decision reflected an attempt to appeal to a greater audience. The Oration was to be followed by a "General Feast".⁸ The Sermon was usually delivered by a distinguished preacher at the church of St. Mary-le-Bow, and its Endowment was the joint product of the will of William Croone of 1684 and of his widow, later Lady Sadleir, in 1706. In the early years of the twentieth century, attendance never exceeded five persons, and in 1923 it was suggested that the Sermon be relinquished.⁹

In 1854, the RCP resolved to have a dinner in the College each year after the Harveian Oration and that distinguished guests should be invited. Over the course of the next 34 years, the dinner was held on June 25th until 1888, when the date was changed to St Luke's Day, 18 October. Toasts became an integral feature of the evening, such that by 1861 twelve toasts were made before dinner started including to Her Majesty The Queen and the rest of the Royal Family, in addition to the House of Lords, the Medical Institutions of the country, and the President of the Medical Council.¹⁰

⁶ Lord Dawson, "Harveian Celebration Committee", 1936, Library of the RCP: 1024/203.

⁷ George Newman, Letter to Mr Barlow (9 August 1923), Library of the RCP: 1024/154.

⁸ According to the terms of the will of the physician William Harvey (1578-1657) who discovered the circulation of the blood.

⁹ Dawson, "Harveian Celebration Committee".

¹⁰ "List of Toasts at the Harveian Diner", 15 June 1861, Library of the RCP: 1024/179.

Public lectures and orations provided medical practitioners with an opportunity for increased visibility within the medical profession. They afforded a prominent display of knowledge, and those who were elected to speak were renowned within the profession; thus, orations and memorial lectures can be seen as a symbol of success. With the exception of the Goulstonian lecture (occasionally spelt Gulstonian) and the Erasmus Wilson lecture, which were given by young medical practitioners, the Harley Street men who delivered public lectures at the RCP, RCS or the Medical Society were well established in their careers: the majority (60 per cent) of the cohort who gave these public lectures were aged between 50 and 70.

Ten per cent ($n = 68$) of medical practitioners, who arrived in Harley Street before 1914 delivered a named lecture: 16 of the cohort gave the Goulstonian Lectures, 13 the Lumleian lectures, 12 the Harveian Oration and six the Croonian Lectures. Leading medical practitioners usually were asked to speak at more than one lecture: Herbert Ritchie Spencer who specialised in gynaecology and obstetrics, gave the Lettsomian Lectures (1920), the Harveian Oration (1921) and the Fitzpatrick Lectures (1927).¹¹ The significance of being selected the speaker in any given year lay in being chosen from a large élite group of physicians and surgeons throughout

¹¹ Herbert R. Spencer, "The Lettsomian Lectures on Tumours Complicating Pregnancy, Labour, and the Puerperium", *BMJ*, Feb. 7 1920, pp. 179-184, Feb. 21 pp. 246-249, Mar. 6, pp. 320-324. *Idem*, *The History of British Midwifery from 1650-1800: the Fitzpatrick Lectures for 1927 delivered before the Royal College of Physicians of London*, (London, 1927). *Idem*, *William Harvey, Obstetric Physician and Gynaecologist: being the Harveian Oration delivered at the Royal College of Physicians, October 18th, 1921*, (London, 1921).

England, which consisted in 1886 of 303 Fellows of the Royal College of Physicians and 1,124 Fellows of Royal College of Surgeons.¹²

Eponymous Lectures at the Royal College of Physicians in London

The Royal College of Physicians held various eponymous lectures that were usually given on an annual basis.¹³ The cachet of these lectures varied, but the most well known up to 1914 were: the Harveian Oration and Lectures, the Goulstonian, Lumleian, and Croonian Lectures (a Croonian lecture was also given at the Royal Society). Other memorial lectures given by the cohort included the Bradshaw lecture, (a Bradshaw lecture was also given at the RCS), the Fitzpatrick lectureship on the History of Medicine, established in 1901, and a Sanitary lectureship on State medicine and public hygiene established in 1886 and also referred to as the Milroy lecture after its benefactor Dr. Gavin Milroy.¹⁴

The Harveian Oration was a luminary occasion during which one of three medals, the Moxton, the Weber Parkes and the Bisset-Hawkins, were presented at various times to physicians for their contribution to the advancement of medicine.¹⁵ The President of the RCP nominated the

¹² Sir George Clark, *A History of The Royal College of Physicians of London*, Vol. II, (Oxford, 1966) p. 739, A. M. Cooke, *A History of The Royal College of Physicians of London*, Vol. III, (Oxford, 1972) p. 1133, and Walter Rivington, *The Medical Profession*, (Dublin, 1888), p. 549.

¹³ Clarke, *History of the RCP*, p. 621. For some such as the Fitzpatrick Lectures (established 1901) or the Oliver-Sharpey Lecture or prize (established in 1904) speakers were elected annually by the President and the Censors of the College to give one or more lectures under the terms of the endowment.

¹⁴ The Fitzpatrick Lectures were published in book form. The origin of the Bradshaw Lecture is summarised in *Lancet*, Dec. 13, 1902.

¹⁵ Anon, "The Moxton Medal Regulations, 1893-1898", RCP: 1002/31. Also see "List of Medals from the Royal College of Physicians", Administration Notebook. (Unpublished: no date), the Library of the RCP, and Gordon Wollenscroft, "Medals Mostly Medical",

speaker from the body of senior fellows of the college and those who declined the invitation were fined by the RCP; the penalty in 1864 was £10.¹⁶ By 1860, speakers were selected for their contribution to the advancement of medical science during the previous year.¹⁷

The Harveian banquet, which was a lavish and expensive affair was open to all FRCPs and, in general, most newly elected fellows attended in their first year but fewer thereafter.¹⁸ One reason for the fall in attendance at the Oration and Banquet, according to Lord Dawson of Penn, was because “a few were attracted by the prospect of a good speech, while others are [were] kept away by the apprehension of dull ones”.¹⁹ Nevertheless, the Oration was published and reprinted in the main medical journals and the national newspapers, thus reaching a wide audience. Guests at the banquet included public and learned figures from the upper echelons of government, medicine, science and universities. A list of attendees at the 1874 Banquet included the Baron of the Exchequer Sir Anthony Pleasby, the Master of Christ’s College, Cambridge and Professor Thomas Henry Huxley.²⁰ Members of Royalty or heads of government were occasionally present; in

Catalogue of an Exhibition, April-September 1986, (Unpublished manuscript: Library of the RCP), Anon, “Weber of Parkes Prize Committee, 1895: the Library of the RCP: 1003/20”.

¹⁶ Anon, ‘Leading Articles’, *BMJ*, Oct. 8, 1864, p. 419. The subject of the oration was originally a tribute to patrons of the College and its aim was to engender mutual respect amongst the members of the College, see Anon, *BMJ*, May 12, 1866, p. 495.

¹⁷ Anon, ‘Leading Articles’, p. 360-361 and Rivington, *Medical Profession, op, cit.*, (12), p. 502.

¹⁸ Anon, Minutes of the Committee meeting of the Royal College of Physicians of London, RCP, November 27th, 1936, p. 4.

¹⁹ *Ibid.*

²⁰ Anon, *BMJ*, March 31, 1866, p. 338 and see “Harveian Banquet: Entertainment Committee Minutes 1874”, RCP: 1024/180-183.

1865, for example, attendees included the Prince of Wales and the Prime Minister, Mr William Gladstone.²¹

The three lectures, the Lumleian, Goulstonian and Croonian, delivered at the RCP were all in English. The annual Goulstonian lecture (established under the will of Dr. Goulston in 1632) was originally to be read by “one of the four youngest doctors [of the College] ... on some dead body” that was to be dissected, according to the President and Elects of the College.²² During every decade from the 1850s to 1914, a Harley Street practitioner delivered at least one Goulstonian Lecture. Several speakers were distinguished medical practitioners and well known in their area of expertise.

William Jenner, who was described at the peak of his success as, “the undisputed leader of the profession” was the first Harley Street practitioner to be appointed Goulstonian lecturer in 1853.²³ In 1850, Jenner had published the results of his research at the London Fever Hospital on typhoid and typhus fevers.²⁴ From 1847 to 1848, he had taken case notes of 1,000 patients suffering from continued fever. Thanks to the work of Drs Lombard in Geneva and of Gerhard and Pennock in Philadelphia, there was growing evidence that the highly contagious typhus fever, more commonly

²¹ Anon, ‘Harveian Society’, *Lancet*, July 1, 1865, p.12

²² Anon, ‘Leading Articles’, p. 355.

²³ Francis Bisset Hawkins delivered the Goulstonian Lecture in 1828 and the Lumleian lecture in 1835; however, he had retired from practice before arriving in Harley Street in 1856. Jenner delivered the Goulstonian lecture in 1853 just prior to establishing a practice in Harley Street between 1854 -1855. He moved to Brook St, Grosvenor Sq. London, in 1869.

²⁴ William Jenner, *On the Identity of Typhoid or Non-Identity of Typhoid and Typhus Fevers*, (London, 1850).

known as gaol fever in Britain, was distinct from typhoid fever. This view, however, did not receive general acceptance until the publication of Jenner's paper. His Goulstonian lecture on the subject was based on this specialist knowledge "with which his name has ever since been identified".²⁵ Other Harley Street practitioners who delivered the Goulstonian lectures included Humphry Davy Rolleston, who was instrumental in founding a society for British radiology and later became President of the British Institute of Radiology. The subject of his 1895 lecture was Addison's disease (caused by the insufficient hormonal production from the adrenal gland).²⁶

Following an endowment from Lady Sadlier, two lectureships were gifted in the name of Dr Croone: "one of these to be read yearly before the College of Physicians, following the sermon and the other on the nature and laws of muscular motion, to be delivered annually before the Royal Society".²⁷ Lady Sadlier later arranged for four-fifths of the endowment to be donated to the RCP and one-fifth to the Royal Society. Lectures were to be on some aspect of anatomy, physiology or pathology and their relation to the prevention or cure of diseases.²⁸ The Croonian lectures were the Royal Society's most prestigious lectures in the biological sciences and those asked to speak were amongst the most prominent scientists and medical

²⁵ Anon, 'Sir William Jenner', *BMJ*, Dec. 17, 1898, p. 1849 and G.H. Brown, *Lives of the Fellows*, (London, 1955), p. 68. William Munk et al, *The Roll of the Royal College of Physicians*, (London, 1955), pp. 352-354.

²⁶ Arpan K Banerjee, 'Sir Humphry Davy Rolleston (1862-1944): a Physician's Contribution to the Development of British Radiology', *Journal of Medical Biography*, Number 3, Aug. 1994, pp. 177-178.

²⁷ Munk, *RCP*, p. 359. It appears from a review of the obituaries that most of the Croonian Lecturers were also fellows of the Royal Society, however, I have not been able to find a source, which stated that this was a requirement. Both Henry Head (1921) and Arthur Gamgee (1902) delivered the Croonian Lecture at the Royal Society.

²⁸ Rivington, *Medical Profession*, *op. cit.*, (12), p. 503

practitioners in the world. Harley Street lecturers joined the ranks of such speakers as T. H. Huxley (1858), Rudolph Virchow (1893) and Ivan Petrovitch Pavlov (1928).²⁹

The first Harley Street physician to deliver the Croonian Lecture in 1871 was Professor Edmund Alexander Parkes who had been a fellow student with William Jenner at University College London.³⁰ Jenner held Parkes in such high regard that he acknowledged, "the desire to possess his esteem has been that which has encouraged me from my earliest student days".³¹ Parkes's had a distinguished record, his Goulstonian Lecture on pyrexia (fever) had been published in *Medical Times and Gazette* in 1855 and in three papers in the *Proceedings of the Royal Society* (two in 1867 and one in 1871). Parkes described the effects of diet and exercise on the elimination of nitrogen, which confirmed independently the work of the physiologist Adolph Fick (1829-1901) and the chemist Johannes Wislicenus (1835-1902).³²

Parkes' Croonian lecture on *Nitrogenous Elimination*, published in the *Lancet* in 1871, was based on the study of the liver as the main organ in the formation of urea. This challenged contemporary views on the subject, such as those developed by the German chemist Baron Justus von Liebig

²⁹ Virchow, '*The Position of Pathology among Biological Studies*', Huxley, '*On the theory of the vertebrate Skull*' and Pavlov, '*Certain problems in the Physiology of the Cerebral Hemispheres*'.

³⁰ Charles West had delivered the Croonian lecture in 1854; however, he did not set up his practice in the Street until 1886.

³¹ Anon, 'Edmund Alexander Parkes', *Lancet*, Mar. 25, 1876, p. 480.

³² E. A. Parkes, 'The Goulstonian Lectures, on Pyrexia', *Medical Times and Gazette*, Lecture I, March 17, 1855, pp. 253-255, March 24, 1855, pp. 279-280, Lecture II, April 7, 1855, pp. 331-335, Lecture III, June 2, 1855, pp. 535-537, June 9, 1855, pp. 561-563.

(1803-1873) who claimed that muscular work implied the destruction of oxidation. Parkes proved that the elimination of urea was not dependent on the amount of muscular exercise, but on the consumption of nitrogenous food, and on the transforming action of the gland-cells, especially those of the liver; he further proved that muscular tissue does not consume itself as a fuel during the work.³³ Thus, the cohort often used public orations to present original research and their findings were sometimes debated at such lectures as the Croonian.

Lord Lumley had established an endowment for the Lumleian Lectures in 1581, which provided for a lectureship in surgery. From 1825 to 1862, the Lumleian lecturer was appointed for a two-year term; thereafter, appointments were done on an annual basis. Alfred Baring Garrod's Lumleian Lectures on uric acid were considered by his contemporaries to be groundbreaking. Lectures such as these, as Watson Cheyne remarked, provided a forum for "criticising the advances that have been made, of seeing what (sic) of these advances are good and what are of doubtful value, and thus of furnishing a basis for further work".³⁴ Cheyne had been Bradshaw lecturer (1908) and Hunterian Orator (1915) and gave the first Lister Memorial Lecture in 1925. Those of the cohort who were elected Lumleian lecturer were all distinguished men and included Richard Quain, Charles West, Reginald Southey, Thomas Jeeves Horder and Frederick Eustace Batten.

³³ Anon, 'Edmund Alexander Parkes, *Lancet*, Apr. 8, 1876, p. 547.

³⁴ A. B. Garrod, 'Lumleian Lectures', *Lancet*, Mar. 24, 1883, p.487 and W.W. Cheyne, Lettsomian Lectures, on 'The Objects and Limits of Operations for Cancer', *BMJ*, Feb. 15, 1896, p. 385.

Experts or specialists in a particular area of medicine or surgery typically gave lectures at the Royal Colleges. Of the Harley Street men who were elected to speak, several including Thomas Jeeves Horder, Philip Henry Pye-Smith, Richard Quain and Charles West, delivered numerous lectures in the course of their career. One such physician, James Mackenzie, one of the leading consultants in diseases of the heart, founded the St. Andrews Institute for Clinical Research and became honorary consulting Physician to King Edward VII whilst he was in Scotland.³⁵ In 1911, Mackenzie delivered both the Oliver-Sharpey Lectures at the RCP on heart failure and the Schorstein Lectures at the London Hospital on auricular fibrillation. He was later selected to be the first George Alexander Gibson Memorial Lecturer at the Royal College of Physicians, Edinburgh in 1914.³⁶

A number of Harley Street benefactors established lectureships, prizes and funds in their own name. In 1903, the Horace Dobell Research Lectures were established at the College in honour of Horace Benge Dobell. The subject of the lectures was to be based on research into "the ultimate origin, evolution, and the life-history of bacilli and other pathogenic micro-organisms".³⁷ Other lectures established in honour of an eminent Harley Street practitioner included: the Ryall Bequest (1936), the Charles West

³⁵ Anon, 'Sir James Mackenzie', *BMJ*, Jan. 31, 1925, pp. 242-245. Others who gave more than one lecture include David Armour, Henry Trentham Butlin, James Andrew and John Mitchell Bruce.

³⁶ *Ibid.*

³⁷ G.H. Brown, *Lives of the Fellows*, (London, 1955), p. 625. See also Anon, 'Horace Benge Dobell', *Lancet*, Mar. 10, 1917, p. 391.

Lectures (1937), the Humphry Davy Rolleston Lectures (1944) and the Gordon-Watson lectures (1952).³⁸

Eponymous Lectures at the Royal College of Surgeons

The RCS was also a beneficiary of endowments for memorial lectures. The most important was the Hunterian Oration (annually from 1813 to 1853, thereafter bi-annually) to commemorate John Hunter (1728-1793). It was a prestigious event, which Royalty attended occasionally and was delivered by a distinguished surgeon.³⁹ Orators from Harley Street, included Sir John Tweedy, Sir Henry Butlin, Sir Anthony Bowlby and Sir William Watson Cheyne all of whom were eminent surgeons

Stephen Jacyna, who examined the historiographical construction of John Hunter's image made by various medical practitioners in the 19th century, argued that the early Hunterian Orators had created Hunter's image by the 1820s. Through their alignment with Hunter, who was variously described as, "the greatest man whom this country has produced in medical science" and "the Shakespeare of medicine" the orators were,

³⁸ *Ibid.* Donated by the wife of Sir Charles Ryall, in his memory, the endowment provides for a Ryall scholar or a paid assistant in the College's museum or Library. The Charles West Lectures are triennial lectures on childhood diseases in honour of West. An annual lecture, usually on diseases of the liver or physiology in honour of Humphry D. Rolleston (1862–1944). The Gordon-Watson lectures, to be delivered every fifth year were provided for by an endowment from Col. M. Gordon-Watson in honour of his father Sir Charles Gordon-Watson. See also the Anon, *Lancet* April 9, 1921, p.777, Dr Murray Leslie also founded a medal at Edinburgh University in honour of his mother who had three sons who were graduates of the University. Anon 'Robert Leslie, M. D', *BMJ*, Apr 9, 1921.

³⁹ For example, when Sir William MacCormac delivered the Hunterian Oration in 1899 the Prince of Wales was in attendance, see Sir William MacCormac, *The Hunterian Oration: delivered on Tuesday, February 14, 1899 at the Royal College of Surgeons of England in Presence of his Royal Highness the Prince of Wales*, (London, 1899).

“actively involved in efforts to advance the social standing of surgeons”.⁴⁰ These orators strived to elevate their status in the medical profession by associating themselves with science as embodied by Hunter. They represented:

the tiny elite of London surgeons, whose interest was to achieve a formal recognition of their social parity with the leading physicians of the capital. These two groups together constituted the nucleus of the consultants who were to dominate the government of the Royal Colleges in future years.⁴¹

Other lectures at the RCS included the Arris and Gale lectures, the Bradshaw lecture and the Thomas Vicary lecture.⁴² The Arris and Gale lecturers were funded by legacies from Edward Arris in 1646 and John Gale in 1655, which were later combined to provide an annual demonstration or lecture on anatomy.⁴³ As with the lectures mentioned above, they also provided a forum to validate innovative practice and satisfy criticism. Henry Hancock, for example, took the opportunity in his Arris and Gale lectures to defend his improvement of Moreau’s excision of the ankle-joint, credit for which “certain writers had endeavoured to deprive him”.⁴⁴

The importance of the Bradshaw lecture (established 1880) was reflected in the stipulation that a senior Member of the Council of the RCS should deliver it and that the subject should advance the medical profession. Between 1845 and 1945, almost a fifth ($n = 31$, 18 percent) of the cohort

⁴⁰ L. S. Jacyna, ‘Images of John Hunter in the Nineteenth Century’, *History of Science*, Vol. 21, 1983, pp. 88, 92 and 96.

⁴¹ Jacyna, ‘Hunter’, pp. 104-105.

⁴² Others include, the Morton lecture (established in 1887) on cancer.

⁴³ Brown, ‘*Fellows*’, p. 8, Footnote 1.

⁴⁴ Anon, ‘Henry Hancock’, *Lancet*, Jan. 17, 1880, p. 111.

were at one time members of this Council.⁴⁵ Charles Alfred Ballance, a member of the Council from 1910 to 1919, described as a pioneer in experimental surgery on arteries and nerves, delivered the Bradshaw lecture on the surgery of the heart in 1919.⁴⁶

The Thomas Vicary Lecture, which covered a particular topic from the history of anatomy or surgery, was instituted at the RCS in 1919. Sir John Tweedy of Harley Street, later professor of ophthalmic medicine and surgery at UCL and President of the RCS in 1903, was the first person to present this lecture.⁴⁷ Tweedy traced the history of surgery from Egypt and Greece and through to the Latin, Arabic and French texts.⁴⁸

In addition to annual lectures or series of lectures, the RCS was also endowed with funds for lectureships such as the Erasmus Wilson Lecture. This lectureship (originally a professorship) was on the subject of dermatology, but in 1880 was changed to pathology.⁴⁹ The exalted status of the speakers was epitomised by Sir Henry Trentham Butlin, who was on the Council of the RCS (1895-1912) and later President (1910-1911) and who became the first Erasmus lecturer in pathology at the RCS. He was an expert on cancer and was regarded as a brilliant lecturer by his contemporaries. Butlin published his lectures on *Sarcoma and Carcinoma: their Pathology, Diagnosis, and Treatment* (1885) and his textbook,

⁴⁵ For a list of the Council Members see, Zachary Cope, *the History of the Royal College of Surgeons of England*, (London, 1959), pp. 342-345.

⁴⁶ Sir Charles Ballance, 'the Bradshaw Lecture on the Surgery of the Heart: Delivered before the Royal College of Surgeons, December 11th, 1919', (London, 1920).

⁴⁷ Cope, *RCS*, p. 338. The announcement was in *Lancet*, Oct. 25, 1919, p. 755.

⁴⁸ Quoted in Anon, 'Sir John Tweedy', *BMJ*, Jan 12, 1924, p. 88.

⁴⁹ Rivington, *Medical Profession, op, cit.*, (12), p. 549.

Diseases of the Tongue, was considered a classic.⁵⁰ In the 1907 Erasmus Wilson lecture, the surgeon Willmott H. Evans challenged the accepted view amongst skin specialists that leucoderma (a change in the pigmentation of the skin) was a disease relating to the nervous system; he proposed that it was, in fact, due to a toxin from the alimentary canal assisted by a local injury.⁵¹

As with the RCP, the RCS established a number of lectureships, honours and trusts that were named after various Harley Street benefactors.⁵² When Sir Berkeley Moynihan was President of the College (1926–1931), he called for donations to advance surgical research: a few distinguished surgeons such as Sir George Buckston Browne responded.⁵³ Browne purchased Darwin's home, Down House in Kent, in 1927 and converted it into a research centre for science. He also established an annual dinner, open to the members and fellows of the college plus invited guests (up to half of the audience was invited to the dinner in memory of his son Lt.-Col. Buckston Browne). Three years later, he endowed the College with £100,000 for the purposes of building and maintaining a centre for surgical and biological research.

Lectures at Medical Societies

The Harveian Society established the Harveian Society Lectures in 1875, initially there were a series of two or three lectures delivered annually, but

⁵⁰ The lectures were published in 1885. Cope, *RCS*, p. 312 and Anon, 'Sir Henry Trentham Butlin', *BMJ*, Feb. 3, 1912, p. 276.

⁵¹ Anon, 'Willmott H. Evans', *Lancet*, Sept. 17, 1938, p. 701.

⁵² For a list of these, see Cope, *RCS*, pp. 333 – 338.

⁵³ Cope, *RCS*, pp. 190-191, 202, 334.

by 1903 the number of lectures had been reduced to one. A decision was made at this time that distinguished members of the profession who were not members of the society, such as foreign medical practitioners, could be invited to give a lecture.⁵⁴ George Buckston Browne was 51 when he was asked to deliver the Harveian Lectures in 1901. The result was that his lectures, which were based on "Twenty-five years of experience in Urinary Surgery in England ... had an immense effect on whatever success he had met with in his profession as a private surgical practitioner in London".⁵⁵

The Medical Society of London's most prestigious lecture, the Lettsomian, was named after their founder and benefactor John Coakley Lettsom (1744-1815).⁵⁶ This annual lecture, which comprised a series of three speeches, was the only one endowed in the society at the end of the nineteenth century.⁵⁷ The Harley Street surgeon Edward William Murphy, Professor of Midwifery at UCL, was one of the first to deliver the course of Lettsomian lectures at the Medical Society. During March 1853, he delivered three lectures on the first, second and third stages of labour, including the associated problems; his third lecture was on the necessity of

⁵⁴ Anon, *The Harveian Society of London: 1831-1981*. (London, no date possibly 1982), p. first page (no page numbers, p. second page).

⁵⁵ Buckston Browne was paid 15 guineas a lecture, see Anon, 'Sir Buckston Browne', *BMJ*, Jan. 27, 1945, p. 132.

⁵⁶ Other societies which held memorial lectures included the West London Medico-Chirurgical Society whose Cavendish lectures were on the application of pathology to surgery. These were published in the *BMJ*, see for example, Anon, *BMJ*, June 1900, pp. 1577-82.

⁵⁷ The Fothergill Medal was triennially from 1920, the Lloyd Roberts Lectures were delivered, in turn, at the Royal College of Physicians, The Medical Society of London and the Royal Society of London. This lecture was given by the Harley Street Herbert Spencer, in 1924

obtaining a scientific education in the practice of midwifery.⁵⁸ Many of his lectures and publications were on the subjects of midwifery and chloroform; he was one of the first surgeons in London to use chloroform in midwifery practice.⁵⁹ Other members of the cohort such as the physician, John Langdon Down, also used the Lettsomian Lectures to disseminate the results of his research.⁶⁰ Langdon Down's 30 year study on the mentally handicapped was presented to the Medical Society and subsequently published in the *BMJ*.⁶¹

These orations and lectures were not only symbols of professional recognition for many of these medical practitioners, but they provided the cohort with the opportunity to embellish such activities as the Harveian Oration, by incorporating rituals and using newly created tradition, thereby adding considerable prestige to the occasion. The lectures also provided a venue for the dissemination of their professional medical expertise and facilitated social interaction amongst those who attended lectures and orations. As will be shown in the next section, professional societies afforded even greater opportunities for professional advancement and especially for the professionalisation of medicine that was occurring at the end of the nineteenth century.

⁵⁸ Edward William Murphy, Lettsomian Lectures for 1853, *Association Medical Journal*, no. 12-15, March 25-April 15, 1853. Delivered at the Society on March 9, 16 and 23, pp. 249-254, 289-293 and 323-329.

⁵⁹ For example, Edward W. Murphy, *Chloroform; its Properties and Safety in Childbirth*, (London, 1855) and *Lectures on Natural and Difficult Parturition*, (London, 1845). See also, Anon, 'Edward William Murphy', *BMJ*, Jan 27, 1877, p. 122.

⁶⁰ Others included Tilbury Fox, who had written extensively on various aspects of dermatology, he gave the Lettsomian lectures on Eczema in 1869-70. For a list of his publications, see Anon, 'Tilbury Fox', *BMJ*, June 14, 1879, p. 916.

⁶¹ J. Langdon-Down, 'Abstracts of the Lettsomian Lectures on some of the Mental Affections of Childhood and Youth', *BMJ*, 1887, pp. 49-50, 148-151, 256-259.

Medical Societies

Membership of clubs and societies had been a prerogative of British gentlemen since at least the seventeenth century, though it was not until the middle of the eighteenth century that professional medical societies were established.⁶² Some of the earliest medical societies of the Georgian period met in coffee houses and gentlemen's clubs: these coffee houses served primarily a social function. In contrast, licensing bodies represented a political role, protecting their members' interests.⁶³ As Roy Porter observed, the eighteenth century clubs that catered for intellectual interests and supported professional ambitions were meeting places; in addition to being a place to socialise, they were also a venue for medical men to exchange ideas and make contacts.⁶⁴ Few medical societies in the Georgian period explicitly promoted medical advancement.

The nineteenth century medical societies, which were also meeting places, were different from the majority of their predecessors because they provided a forum for sharing, promoting and advancing medical knowledge within the medical profession at large. The aims and profiles of the medical societies that arose in the 1850s had closer links to those of the Royal Society (established in 1662), the Medical Society of London (1773) and to such student medical societies as the Medical and Philosophical Society at Bart's (renamed the Abernethian Society in 1832) that sprang up in the late

⁶² Sir D'Arcy Power, (ed.) *British Medical Societies*, (London, 1939), p. vii., Roy Porter, *London a Social History* (London, 1996), see also Peter Clark, *British Clubs and Societies, 1580-1800: the Origins of an Associated World*, (Oxford, 2000).

⁶³ Porter, *London*, p. 170.

⁶⁴ *Ibid.*, pp. 178-179.

eighteenth century, than to the coffee houses and gentlemen's clubs.⁶⁵ The Royal Society, in particular, played a critical role in the dissemination of scientific and medical knowledge and became a template for many of the medical societies, which were established by the middle of the nineteenth century.

W.H. McMenemey drew a distinction between the medical *societies* and medical *associations* that developed towards the end of the eighteenth and the first quarter of the nineteenth centuries. Medical societies, he argued, were scientific and social in contrast to the emerging medical associations, which were "medico-political combinations ... the majority were convened to foster legislation for improving the professional education of doctors".⁶⁶ Most of these associations were interested in supporting regulations to curb unqualified practitioners and in protecting the interests of their members.⁶⁷ The most prominent was the Association of Apothecaries and Surgeon Apothecaries formed in 1812 (in 1826 it changed its name to Associated General Medical and Surgical Practitioners) whose focus was the regulation, recognition and reform of the surgeon apothecary.⁶⁸

⁶⁵ Penelope Hunting, *The History of the Royal Society of Medicine* (London, 2002), pp. 1-3 and p. 5. There were two other early Medical Societies, one established in Edinburgh in 1731: the Medical Society and another in London in 1752 called the Medical Society, this was not connected to the later Medical Society founded in London 1773.

⁶⁶ W.H. McMenemey, 'The Influence of Medical Societies on Development of Medical Practice in Nineteenth-Century Britain' in F.N.L. Poynter, (ed.), *The Evolution of Medical Practice in Britain*, (London, 1961), pp. 67-68.

⁶⁷ For details of these medico-political associations established up to the late 1880s see, Rivington, *Medical Profession*, pp. 465-486.

⁶⁸ Irvine Loudon, *Medical Care and the General Practitioner: 1750-1850*, (Oxford, 1986), Chapter 7 and p. 279

The first half of the nineteenth century witnessed a burgeoning of clubs for the professional middle-classes such as lawyers and scientists, which included a proliferation of societies for medical practitioners.⁶⁹ Penelope Corfield argued that membership of these organisations, which emerged during this period, contributed to the feeling of group identity and combined conviviality with mutual assistance.⁷⁰ As the numbers of medical practitioners rose throughout the Victorian period, many medical students found employment increasingly difficult to procure, thus they had to look for staff positions outside their alma mater. Medical societies provided a venue for students to meet influential members of other medical schools, thereby increasing their chance of gaining a staff position. By the 1850s, medical societies served as a conduit of general and increasingly specialist knowledge.⁷¹

New medical societies emanated from existing groups such as medical book clubs and social clubs; however, the organisations that arose in the 1850s began to promote the dissemination of medical knowledge and the establishment of a professional standard within the medical arena.⁷² In his paper on “The Place of Medical Societies in the Progress of Medicine”, Sir Raymund Crawford maintained that whilst the diffusion of knowledge was

⁶⁹ *Ibid.*, and Peter Clark, *British Clubs and Societies 1580-1800: the Origins of an Associated World*, (Oxford, 2000), p. 114.

⁷⁰ Penelope J. Corfield, *Power and the Professions in Britain: 1700-1850*, (London, 1995), p. 159.

⁷¹ Anne Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford, 1999), p. 62.

⁷² The Manchester Medical Society formed in 1834 arose out of a medical book-circulating club. See Philip Swann, ‘A brief summary of the Role and Position of Medical Societies in the early Nineteenth Century Medical Profession’ *The Journal of Local Studies*, Vol.1, Summer, 1980, pp. 43-46.

the principal function of medical societies, the acquisition and creation of new knowledge was becoming of paramount importance.⁷³ To Crawford, medical societies played an important role in fostering conviviality, which he saw as essential for productive professional cooperation. Membership thus appealed to the London medical élite because it served “as a place for introductions and professional connections amongst consultants”.⁷⁴

Membership of Medical Societies

A collection of papers printed in the *Medical Press and Circular* between 1936-38 compiled by Sir D'Arcy Power in 1939, remains the most comprehensive history of British medical societies in the nineteenth century.⁷⁵ Though even D'Arcy Power realised that “they [were] not a history of all the British Medical Societies, for that would be a very difficult task” to undertake.⁷⁶ Individual histories of general medical societies, such as Peter Bartrip's, *Themselves writ Large: the British Medical Association, 1832-1966*, together with histories of specialist societies such as the *History of the Physiological Society* by Edward Sharpey-Schafer are a valuable reference for the historian, in lieu of a general history of medical societies in the nineteenth and twentieth centuries.⁷⁷ The more prestigious societies such as the Royal Society have, however, received considerable attention

⁷³ Sir Raymond Crawford, ‘The Place of Medical Societies in the Progress of Medicine’, Harveian Oration on the Occasion of the Centenary of the Harveian Society of London: 11 June, 1931, Archives of the RCP/ 245/2, pp. 3 and 14.

⁷⁴ M. Jeanne Peterson, *The Medical Profession*, (London, 1978), p. 18.

⁷⁵ For the period before 1800, see Peter Clark, *British Clubs and Societies*, *passim*.

⁷⁶ Power, *Medical Societies*, p. viii.

⁷⁷ Peter Bartrip, *Themselves writ Large: the British Medical Association, 1832-1966*, (London, 1996), see also Ernest Muirhead Little, *History of the British Medical Association*, (London, 1932). Sir Edward Sharpey-Schafer, F.R.S. *History of the Physiological Society during its first fifty years: 1876-1926* (London, 1927).

from historians of science and a number of these studies include commentaries on other societies.⁷⁸

The recent *History of the Royal Society of Medicine* by Penelope Hunting and the earlier book published by the RSM, *The Royal Society of Medicine* by Maurice Davidson are particularly useful, as they incorporate the histories of the societies that merged in the early 1900s to form the RSM.⁷⁹ Their work provides a valuable framework for the history of medical institutions. Further research remains to be done and as Irvine Loudon pointed out, "a comprehensive history of medical societies has yet to be written".⁸⁰

By 1913, it was estimated that there were "at least 132 Medical Societies in this country, England claiming 104 (28 in London and 76 in the Provinces)", which excluded students' associations or benevolent societies.⁸¹ Thus, one of the difficulties in analysing the medical societies that had members from Harley Street is their quantity and diversity. It will be shown that Harley Street practitioners participated in this rapid development and proliferation of medical societies from 1845 to 1914. The number of memberships listed by the male cohort in the *Medical Directory* increased dramatically in this period, but this was partly because the style and

⁷⁸ See, for example, David Philip Miller, 'The Royal Society of London 1880-1835: A study in the cultural politics of scientific organisation', (Ph.D. dissertation, University of Pennsylvania, 1981) where he discusses the Linnean Society and the Astronomical Society, amongst others and Sir Henry Lyons, F.R.S. *The Royal Society: 1660-1940: A History of its Administration under its Charters* (Cambridge, 1944) and Sir Harold Hartley, F.R.S. (ed.) *The Royal Society: Its Origins and Founders*, (London, 1960).

⁷⁹ Hunting, *RSM, passim* and Maurice Davidson, *The Royal Society of Medicine*, (London, 1955).

⁸⁰ Loudon, *Medical Care*, p. 281.

⁸¹ Jamieson B. Hurry, *The Ideals and Organisation of a Medical Society*, (London, 1913), p. 9.

content of the *Directory* altered over the period. In the decade from 1845 to 1855, it was less common to include membership of medical societies in the *Medical Directory*. This did not, of course, necessarily imply that these practitioners were not members of organisations, rather that they may not have reported it. By 1914, listing membership of professional associations or societies was common and the increased variety of memberships became markedly diverse. This increase could be attributed to the rise of specialist organisations and the expansion of overseas memberships during the last quarter of the nineteenth century.

The total number of societies that the cohort joined was approximately 300, which included societies in the UK and abroad. The majority of these ($n = 239$) had only one member from Harley Street before 1914 and are, therefore, numerically unimportant; however, their significance lies in the spread of the cohort's memberships.⁸² Many of the men in the group, particularly those who were eminent in their field, such as John Langdon Down and George Harley, were members of a large number of learned societies and were occasionally invited to be corresponding members of overseas academies and institutions.⁸³ Harley Street practitioners, such as Edward Farquhar Buzzard who belonged to at least a dozen medical organizations, were assiduous attendees and orators

⁸² 46 societies had two members or fellows from Harley Street, 13 had 3, 5 had 4, 3 had 5 and 7 had 6.

⁸³ Langdon-Down's memberships included the Anthropological, Medico-Psychological, Neurological, Pathological, New Sydenham, the Medical Societies and the BMA. Harley was a corresponding member of the Microscopical Society of Giessen, the Medical Society of Halle, the Badish Society of Medical Jurists, the Royal Academy of Medicine of Madrid, and the Academy of Sciences of Bavaria. Mrs Alec. Tweedie, (ed.) *George Harley F.R.S. or the Life of a London Physician*, (London, 1899), pp. 170–171.

at a variety of medical meetings.⁸⁴ Since these meetings were reported in the medical press, Buzzard's biographer argued that such attentiveness was judicious.⁸⁵

Table 5.1 Appendix E displays the main London society memberships of the cohort, (i.e. over seven or more members from Harley Street, or greater than one per cent). Medical Societies in which Harley Street men were prominent or made a significant contribution are discussed below. Digby's analysis of 961 GPs revealed that between 40 to 50 per cent were members of medical societies.⁸⁶ The figure for Harley Street was, however, much higher: the majority, which comprised 84 per cent ($n = 545$) of Harley Street practitioners were members of at least one medical society by the time of their arrival in the Street. Of those who were not members, that is, 112 (16 per cent), 38 of these listed their membership of a medical society in the *Medical Directory* before they left Harley Street. Thus, almost 90 per cent ($n = 583$, 88.74 per cent) were members of a medical society during their time in the Street. On average, twice as many Harley Street men were members of a medical society compared with Digby's findings on general practitioners in Britain. It is not surprising that the figure for Harley Street was higher, as London was the centre of medical societies in the period and many of the main organisations were within easy reach of Harley Street.

⁸⁴ For a list of the medical societies, see A. M. Cooke, *Sir E. Farquhar Buzzard, Bt. K.C.V.O., D.M., F.R.C.P. An Appreciation*, (Oxford, 1975), p. 11.

⁸⁵ *Ibid.*

⁸⁶ Digby, *General Practice*, pp. 6 and 62.

As was mentioned in Chapter 2, the City and the Finsbury Square area, in particular, were the most popular places in which to establish a practice up to the 1840s. From the middle of the century, the slow westward migration had begun and practices in St James, Savile Row, Mayfair and Marylebone were the preferred choice. This westward relocation had an effect on some of the medical societies such as the Medical and Chirurgical Society. Members who were dissatisfied with the "inconvenient location" of the Medical and Chirurgical Society at Lincoln's Inn Fields petitioned for the society's removal to the West End. Agents were also dispatched to assess the possibility of Wimpole Street, although suitable accommodation could not be found there and the society eventually leased a house in Berners Street near the Middlesex Hospital in 1834.⁸⁷

The Medical and Chirurgical Society moved closer to Harley Street in 1889 when they relocated to Hanover Square where they remained for 21 years, until the temporary move to Cavendish Square in 1910. By then, the society was part of the RSM, which moved to 1 Wimpole Street two years later. Other societies who wanted a West End location included the Pathological Society, the Clinical Society, the Zoological Society and Harveian Society all of which were invited by the Royal Medical and Chirurgical Society to take rooms at Berners Street.⁸⁸ The Medical Society, the British Gynaecological Society and the Ophthalmological Society were

⁸⁷ Hunting, *RSM*, pp. 61-2.

⁸⁸ *Ibid.*, pp. 73-74.

also convenient to Harley Street, being in 11 Chandos Street, Cavendish Square.

London medical societies ranked differently in terms of prestige; some, such as the BMA, were egalitarian and open to all medical practitioners whilst others, such as the Medico-Chirurgical Society, the Hunterian Society and the Medical Society of London were more exclusive and had fewer members. Peterson maintained that these selective societies “seem to have been the preserve of the London elite, serving as a place for introductions and professional connections amongst consultants”.⁸⁹

Scientific Societies

The most prestigious of all scientific societies led George Harley to remark that, “everyone knows by reputation the Royal Society, which allows its Fellows to use the magic letters F.R.S. after their name”.⁹⁰ Established in 1662, the Royal Society remained unique until the middle of the eighteenth century. From that period onwards, specialist societies interested in particular aspects of the natural sciences began to form, such as the Linnean Society (1788), the Horticultural Society (1804) and the Astronomical Society (1820). Increasing interest in scientific knowledge and its relevance to industry in the late nineteenth century led to demands for restructuring the Royal Society amongst a number of its scientific fellows known as the reformers.⁹¹ In his book, *The Royal Society in the Nineteenth-Century*, A.B. Granville criticised the way in which the society was run

⁸⁹ Peterson, *Medical Profession*, p. 18, footnote (no number).

⁹⁰ Tweedie, *Harley*, p. 333.

⁹¹ *Ibid.*, p. 242.

during this period.⁹² He disapproved of the society's selection procedure, because they accepted members who were genuinely not interested in science and he felt that the society had changed into "an ordinary club".⁹³

By the beginning of the First World War, however, the Royal Society was becoming increasingly more scientifically based. Twenty-four (4 per cent) of the Harley Street cohort were elected FRS, which was a considerable number as from 1845 to 1914 there were 1,318 Fellows of whom 151 (11 per cent) had medical qualifications.⁹⁴ Those from Harley Street included distinguished medical practitioners such as Sir George Buchanan (1882), Sir William Watson Cheyne (1894), Sir Charles Mansfield Clark (1825), Sir Thomas Spencer Cobbold (1864), Sir Henry Head (1899) and Sir Gordon Morgan Holmes (1933). An analysis of the FRSs from Harley Street indicated that they were not concentrated in any particular decade; they were spread throughout the period.

George Busk was elected FRS in 1850 and later appointed Vice-President of the Royal Society on four occasions. Busk was also the first secretary of the Zoological Society (1860-1869). A distinguished scientist, he was an authority on craniometry, palaeontology and marine zoology. In 1846, he formulated the first scientific arrangement of the Bryozoa (Polyzoa), a type of primitive mollusc. He was the editor of a number of scientific journals: *Microscopic Journal*, *Quarterly Journal of Microscopic*

⁹² A. B. Granville, *The Royal Society in the Nineteenth-Century*, (London, 1836).

⁹³ E. N. Da C. Andrade, *A Brief History of The Royal Society* (London, 1960), p. 11.

⁹⁴ 'List of the Fellows', Archives of the Royal Society. Some of the Harley Street cohort, such as the neurologist Sir Gordon Holmes (1933) were elected FRS after their departure from the Street, see Davis Coakley, *Irish Masters of Medicine*, (Dublin, 1992), p. 261.

Science, Natural History Review and *Journal of Ethnological Society*. With Thomas Henry Huxley (1825-1895), he translated and edited Albert von Kölliker's (1817-1905) *Manual of Human Histology* (1853) and was later editor and translator of Carl Wedl's (1815-1891) *Rudiments of Pathological Histology* (1855).

An increased interest and knowledge of minerals, plants and animals in the early 1700s, led to the establishment of the Botanical Society (1721), followed in 1745 by the Aurelian Society (to study of insects) and in 1780, the short-lived Society for Entomologists of London.⁹⁵ The Linnean Society, one of the most popular of the new natural societies with the cohort, is discussed below.

The Linnean Society was established in 1784 to commemorate Carl Linnaeus (1707-1778), the Swedish botanist and physician who founded the modern taxonomical system of the classification of plants and animals. George Busk later became under-Zoological Secretary and J.J. Bennett, a non-Harley Street botanist was appointed as secretary of the Linnean Society.⁹⁶ Busk succeeded to the position of sole secretary in May 1860, being the society's first zoological secretary and he held this position until 1869. There was a slight increase in the popularity of the Linnean Society amongst arrivals in Harley Street during Busk's tenure when Henry

⁹⁵ Andrew Thomas Gage, *A History of the Linnean Society of London*, (London, 1938), p. 1. The Society for Promoting Natural History formed in 1782 was active until 1800, but the society lost many of its members to the newly established Linnean Society in 1788.

⁹⁶ Gage, *Linnean*, p. 55.

William Haden-Haden, Thomas Spencer Cobbold, John Thompson Dickson and W.H. Podmore-Jones joined the society.

As a classifier and investigator, Busk's work provided corroborative evidence of the ideas of his neighbour, Charles Lyell who also lived and worked in Harley Street, as well as Charles Darwin and Richard Owen. Busk was member of the X Club (a dining club united in defence against the evolutionary naturalism promoted by evangelical scientists) along with Sir Joseph Hooker, Huxley, John Lubbock, Herbert Spencer and John Tyndall who advocated that science should be independent of theology. Busk was President of a number of scientific societies including the Ethnological Society and the Microscopical Society of which he was a founder member.

General Medical Societies in London

In the report from the meeting at the Royal Medical and Chirurgical Society in April 1905, the Chairman, Sir William Church, defined general medical societies as those that "embrace[d] all medicine and the subjects that [were] allied to it" and included: the Medical Society, the Royal Medical and Chirurgical Society, the Hunterian Society and the Harveian Society.⁹⁷

Following the exclusion of the eighteenth century physician, John Coakley Lettsom from the fellowship of the RCP, because he was neither an Oxbridge graduate nor a member of the Church of England, he conceived of the idea of bringing together physicians, surgeons and apothecaries in one society. He established the first democratic medical society in Britain, the

⁹⁷ Anon, *The Royal Society of Medicine*, (London, 1914), p. 86.

Medical Society of London in 1773.⁹⁸ Lettsom modelled the Society after the RCP, but also provided a forum for the three branches of medical men and facilitated the advancement of medical knowledge.⁹⁹ From its inception, the society was keen on promoting research and new ideas. Irvine Loudon found that by the late nineteenth century, the Medical Society of London had become “the most prestigious of all London medical societies”.¹⁰⁰ As Sir Christopher Booth observed, this society was “the first medical organisation, apart from the Royal Society, to encourage research by awarding medals for outstanding contributions”.¹⁰¹ Between 1848 and 1941, almost a quarter of the Presidents of the Medical Society of London were Harley Street men, (21 out of 93 of the Presidents): which included Herbert William Carson (1927), Arthur Ernest Sansom (1897) and Vincent Warren Low (1919).¹⁰² Carson was one of the founders of the North East London Post-Graduate College. A frequent speaker at medical societies, his main interest was in abdominal surgery.¹⁰³ Sansom was responsible for bringing Pasteur’s research on fermentation to the Medical Society in a series of papers, which were later published in *The Antiseptic System* (1871).¹⁰⁴ Low was elected President of the Medical Society in 1919 and later became one of its trustees.¹⁰⁵

⁹⁸ Crawford, ‘Medical Societies’, p. 11.

⁹⁹ *Ibid.*, The Medical Society was arranged in a similar hierarchical structure as the RCP with a president, treasurer, registrar and council.

¹⁰⁰ Loudon, *Medical Care*, p. 201.

¹⁰¹ Christopher C. Booth, *Doctors in Science and Society: Essays of a Clinical Scientist*, (Cambridge, 1987), p. 9.

¹⁰² Three were Presidents just before their arrival in Harley Street and four were appointed President following their departure from the Street.

¹⁰³ Anon, ‘Herbert William Carson’, *Lancet*, Sept. 6, 1930, p. 556.

¹⁰⁴ Anon, Arthur Ernest Sansom, *BMJ*, Mar. 23, 1907, p. 722.

¹⁰⁵ Anon, ‘V. Warren Low’, *BMJ*, Sept. 19, 1942, p. 354.

The drawn out tenure and inflexibility of the President of the Medical Society, Dr. James Sims, led a number of influential members to set up the Medico-Chirurgical Society, as a separate organisation in 1805, which received its charter in 1834 and became the Royal Medical and Chirurgical Society (RMCS). Entry to membership was by ballot. The society's name was a reflection of the development of modern scientific surgery following the practices of John Hunter, which represented "the emancipation of surgery from the mortmain of medicine".¹⁰⁶ The largest of the London medical societies, it was situated conveniently in Berners Street, Oxford Street and popular with the cohort as 109 fellows (18.49%) were from the Harley Street.

Though the RMCS was accessible for those in the West End, many felt there was a need for a medical society within easy access of the City and the eastern district of London. Consequently, the Hunterian Society was established by William Cooke in 1819, in memory of John Hunter (1728-1793). At the time "many practitioners lived within the boundaries of the Old City of London, in and around Finsbury Square, which was then the 'Harley Street' area."¹⁰⁷ The Harley Street surgeon Robert Fortescue Fox was Honorary Secretary at the time of the proposed affiliation with the RSM and his neighbour, Sir William Blizard, who was an ex-pupil of Hunter who

¹⁰⁶ John Hunter believed that theories had to be tested scientifically certainty could only be established through research and observation. Crawford, 'the Place of Medical Societies', p. 12.

¹⁰⁷ A. E. Mortimer Woolf, 'The Hunterian Society', in Power, *Medical Societies*, p. 78, fn., 18.

proposed the society's name, became its first President.¹⁰⁸ Several other Harley Street men held senior positions within the society and they included the surgeon Herbert William Carson who was President during the early twentieth century.¹⁰⁹

Whilst the Hunterian Society catered for the medical profession in the East End, the West London Medico-Chirurgical Society served those in the Hammersmith and Fulham areas and the Harveian Society catered for those in the West End. Established in September 1831, the Harveian Society was originally called the Western London Medical Society because of the venue for the society's meetings in the Western General Dispensary, Lisson Grove, London. It became the Harveian Society later in the month as a "token of its resolution strictly to adhere to the course of observation and induction so successfully pursued by the illustrious discoverer of the circulation of the blood".¹¹⁰ The aims of the society were the advancement of medical science through debate in addition to meetings to discuss unusual medical cases. From 1851, the society's meetings were held at the Medical Society of London and two years later, it opened its doors to corresponding members.

The Council decided that a general practitioner should be elected president of the society triennially. Harley Street produced a number of the society's presidents, at least one per decade from the 1830s to the 1900s, and

¹⁰⁸ E. F. Stewart, 'The Hunterian Society: 1869-1969', *History of Medicine*, Autumn 1970, p. 8

¹⁰⁹ Anon, Herbert William Carson, *Lancet*, Sept. 6, 1930, p. 556.

¹¹⁰ Anon, *The Harveian Society of London: 1831-1981*. (London, no date possibly 1982) p. first page (no page numbers). Women were not admitted as full members until 1964.

some of these included, William Macintyre (1838-39 and 1845-46), Sir Richard Quain (1853), Thomas Carr Jackson (1877), William Hickman (1882), Sir Malcolm Morris (1893) and Sir William Watson Cheyne (1902). All were distinguished and established medical practitioners who had also been presidents of other medical associations.¹¹¹ The Right Honourable Lord Horder, consulting physician to Bart's (1936) who was described as "as the greatest physician of his day", was elected President in 1931.¹¹²

British Medical Association (BMA)

The British Medical Association was the most popular organisation for the cohort and many Harley Street practitioners were prominent members. As Peter Bartrip has shown, the BMA was never designed by unanimous agreement or by statute to fulfil any one exclusive duty. Its essence changed over time with goals being adapted.¹¹³ It was the principal medical society for members of the medical profession throughout the British Empire and had 12,000 members in 1886.¹¹⁴ Peterson noted that by the 1890s, more than half of all registered medical practitioners were members of the BMA.¹¹⁵ At least 30% of the new arrivals in Harley Street listed their BMA membership in the *Medical Directory*. The Association had an extensive system of branches throughout the country and each branch elected at least

¹¹¹ For a list of Harveian Presidents, see Anon, *Harveian Society*, pp. 6-9, (no page numbers).

¹¹² *Ibid.*, p. Appendix Biographies of some of the Presidents'.

¹¹³ Peter Bartrip, *Themselves Writ Large, the BMA, 1822-1936*, (London, 1996).

¹¹⁴ Rivington, *Medical Profession*, *op. cit.*, (12), pp. 452 and 478. For a comprehensive history of the BMA, see Bartrip, *BMA*, *passim*.

¹¹⁵ Peterson, *Medical Profession*, p. 231.

one representative annually.¹¹⁶ The main objective of the Association was to improve medical science and enhance the status of the medical profession.¹¹⁷ Thus, by the 1950s, Paul Vaughan remarked that

at one time, and not so very long ago, a generally held opinion was that the BMA was run by 'diehard old fossils', 'a small body of politically-poisoned people, Harley Street guineas grabbers'.¹¹⁸

Though a number of people regarded the BMA with some disdain because of the involvement of so many men from Harley Street, it was, nevertheless, a democratic Association which represented the views of the majority of active medical practitioners in Britain and thus exercised a high degree of "lobbying potential".¹¹⁹

It was common for the cohort to join the BMA early in their career and some worked their way through increasingly senior posts: a trajectory which also reflected their career advancement.¹²⁰ The ophthalmologist Nathaniel Bishop Harman who joined the BMA just after qualifying, worked his way up from secretary of the Marylebone Division to Honorary Secretary and Treasurer of the Branch Division, and he served as Branch President in 1922-23. Two years later, he was appointed Treasurer of the BMA, which he held until 1939 — becoming the longest holding member to date of that office. In 1931, he was awarded the Gold Medal for his service to the Society and for his pioneering work in ophthalmology, especially in the prevention of blindness.

¹¹⁶ Branches with more than 200 members elected an additional representative who also had a position on the council. Rivington, *Medical Profession*, p. 479.

¹¹⁷ Little, *BMA*, pp. p. 296.

¹¹⁸ Paul Vaughan, *Doctors' Commons, a Short History of the British Medical Association*, (London, 1959), p. xiv.

¹¹⁹ *Ibid.*

¹²⁰ Anon, 'Septimus William Sibley', *BMJ*, March 25, 1893, p. 671.

Other Harley Street practitioners who were actively involved in the BMA included Septimus William Sibley who was President of the Metropolitan Counties Branch of the BMA 1878 and later Treasurer. He was a member of the Council from 1881 to 1891. Henry Radcliffe Cocker became honorary secretary of the association's Counties Branch in 1889, two years later he was elected a representative of the Branch on the Central Council, and finally in 1907, he was elected Treasurer.¹²¹ In general, those who were members of a number of societies were also members of the BMA. Charles Oliver Hawthorne who was described as a "good committee man" was "at one time or another ... a member of thirty committees or subcommittees of the Association".¹²² In 1924, he became a member of the Council and was Chairman of the Representative Body from 1928 to 1931.

Appointment to the position of President of a section was for some a humbling experience and a role they took seriously. When Tilbury Fox was elected as President of the Dermatological Subsection in the Section of Medicine at the BMA, he remarked in a letter to his friend, and Harley Street colleague, Professor Macnaughton Jones: how much he appreciated the honour conferred upon him and in accepting the presidency, which he did, "with considerable diffidence", he pledged to make the meeting a success "as far as dermatology is concerned".¹²³

¹²¹ Anon, 'Henry Radcliffe Crocker', *BMJ*, Sept. 11, 1909, p. 730.

¹²² Anon, 'Charles Oliver Hawthorne', *BMJ*, Oct. 29, 1949, pp. 986-87.

¹²³ Anon, 'Tilbury Fox', *BMJ*, June 14, 1879, p. 916.

Hospital Medical Societies and University Clubs

Most of the Medical Schools had students' societies. The oldest of these was the Edinburgh Royal Medical Student Society established in 1735, followed by Guy's Physical in London in 1775 and the Medical and Philosophical Society in 1795. The aims of these societies were twofold: they provided a forum for the reading of papers on medical and surgical subjects, and facilitated the exhibition of specimens and the discussion of patient case histories. Many of the cohort maintained strong links with their university or hospital, particularly if they were appointed to its staff. They also undertook voluntary work for these institutions, which sometimes led to the establishment of student societies.

From 1908 to 1926, the Presidents of King's College Hospital Medical Society were the Harley Street surgeons Frederic Burghard and Lionel Vernon Cargill who were ex-students of Kings.¹²⁴ Cargill, who graduated from King's, had a life long bond with his medical school. He excelled academically, winning scholarships and prizes, which included the Carter gold medal and in 1888, the "Todd prize for clinical medicine and prizes for obstetrics, pathological anatomy and forensic medicine".¹²⁵ From 1902-1903, he was President of the College's Medical Society at the hospital and was later appointed president of the Clubs and Societies Union.¹²⁶ Cargill was appointed consulting surgeon to the hospital and later became a lecturer in ophthalmology. Other Harley Street King's men included George Belben

¹²⁴ Anon, 'L.V. Cargill, *BMJ*, Dec. 24, 1955, pp. 1568-69.

¹²⁵ *Ibid.*

¹²⁶ *Ibid.*

Flux who qualified in 1888, and was appointed Assistant Anaesthetist in 1902; he was largely responsible for establishing the King's College Hospital and Societies Union in 1908.¹²⁷ This union incorporated the Listerian Society together with sporting societies and other leisure pursuits.

The surgeon, John Abernethy (1764-1831) is regarded by historians as the principal founder of the medical school at St. Bartholomew's Hospital. He established his series of anatomical lectures in 1788, at the hospital and seven years later, in 1795, he created the Medical and Philosophical Society for the teachers and students and alumni of the hospital.¹²⁸ This was renamed the Abernethian Society in 1832, in honour of its founder.¹²⁹ Papers on medical science and practice were presented at the weekly meetings during the winter session and results of clinical cases were displayed. However, information concerning the formative years of the society is sparse, especially since "no authoritative record of the Society is known to exist" between 1815 and 1832.¹³⁰ Keir Waddington noted that the high point for the society was in the 1870s and 1880s, when with papers that encompassed the relatively new subjects of pathology and bacteriology it became more scientific.¹³¹ Attendance began to decline in the twentieth

¹²⁷ H. Willoughby Lyle, *King's and Some King's Men*, (London, 1935) p.427

¹²⁸ Victor Cornelius Medvei and John L. Thornton, (eds.) *The Royal Hospital of Saint Bartholomew: 1123-1973*, (London, 1974), p. 47

¹²⁹ Medvei, *Bart's*, p. 55.

¹³⁰ 'A brief sketch of the 'Abernethian' – some time known as the 'Medical and Philosophical' – Society of St. Bartholomew's, Rowland H. Coombs in Dr. Andre and Mr Callender, (eds.), *Saint Bartholomew's Hospital Reports*, Vol. IV, 1868, (London, 1868), p. 269.

¹³¹ Keir Waddington, *Medical Education at St Bartholomew's Hospital, 1123-1995*, (Suffolk, 2003), pp. 247-258.

century when students were taught these new subjects in the class-room and the society lost its research focus.

In the 1834-35 session, the Harley Street physician, Charles West, submitted a number of papers to the Abernethian Society, including "Structure and Functions of the Placenta" and "On the difficulties in the diagnosis and treatment of Head affections in Children".¹³² As was noted by a fellow member, West's growing reputation as an expert in obstetrics could "have been marked out by his papers at the Abernethian".¹³³ He later delivered the Croonian lectures (1854), the Lumleian Lectures (1871) and the Harveian Oration (1874). The election of Mitchell Henry to the presidency for the 1847-48 session coincided with a brief period of financial prosperity for the Abernethian Society. By 1856, however, the society was forced to discontinue the practice of publishing its transactions due to lack of funds.

The record of members of the Abernethian Society just after the Great War showed that more members were from Harley Street and the Harley Street Area than from any other region.¹³⁴ They included the surgeon William McAdam Eccles who graduated MB in 1890, BS in 1891 and MS in 1894 from UCL. He later became a lecturer in surgery and took a keen interest in education and opportunities for recent medical graduates. Consequently, he became one of the founders of the University of London

¹³² Coombs, *Abernethian*, p. 277.

¹³³ *Ibid.*

¹³⁴ F.W. Andrews, W. McAdam Eccles, G.E. Gask, W.D. Harmer, H. Thursfield, and H. Williamson eds., *Saint Bartholomew's Hospital Reports* Vol. Liii, 1917 and 1918, (London, 1920), pp. xi-xxiii.

Medical Graduates Club.¹³⁵ Eccles was also President of the West London Medico-Chirurgical Society.¹³⁶

Medical Clubs

Informal associations for physicians and surgeons in London such as dining clubs and bridge clubs continued to be created during the period.¹³⁷ Many were formed around a hospital, such as the United Hospitals Club for Guy's and Thomas's or other institutions such as the Royal Colleges of Surgeons or Physicians. Some were fairly exclusive and consisted of fellows or senior members of staff; the RCS had a Council Club for members of the council and the RCP had a College Club for the "inner ring" which was "very select [with] (only 22) members".¹³⁸ Another club founded to cater for an élite group of physicians and surgeons was the Samuel Wilks Fifteen Club, named in honour of Samuel Wilks (1824-1911), physician to Guy's Hospital and regarded as one of the founding fathers of clinical science.¹³⁹ The club owed its origin to two physicians at Westminster Hospital, one of whom was the Harley Street resident Horatio Bryan Donkin, the club's secretary.¹⁴⁰ Donkin, who was on the Committee of the Savile Club, moved freely in radical and socialist circles and was described as a "progressive thinker", in

¹³⁵ Anon, 'William McAdam Eccles', *BMJ*, 15 June, 1946, pp. 892-93.

¹³⁶ Anon, 'William McAdam Eccles', *Lancet*, June, 8, 1946, p. 873.

¹³⁷ Sir Humphry Rolleston, 'Medical Friendships, Clubs and Societies', *Annals of Medical History*, Vol. II, May, 1930, Number 3, p. 253.

¹³⁸ *Ibid.*

¹³⁹ Anjan K. Banerjee, 'Sir Samuel Wilks: a Founding Father of Clinical Science', *Journal of the Royal Society of Medicine*, Jan. 1991, vol. 84, p.44.

¹⁴⁰ Sir Bryan Donkin, *The Samuel Wilks Fifteen Club: A Record from its Foundation in February 1885, to May 27, 1926*, (London, 1926), p. 1. The club's eponym Sir Samuel Wilks, senior physician at Guy's Hospital and a leading authority on morbid anatomy (1823-1910) appeared to be a reluctant President. When "begged" by to accept the position, Donkin stated that Wilkes's "modesty at first forbade his assent" adding later that Wilkes refused to accept the office for more than a year.

part because he was a member of the Men and Women's Club, established in the late 1880s, by the eminent Victorian statistician, Karl Pearson (1857-1936) and his Cambridge friend, the barrister Robert Parker, for the open discussion of relations and problems between the sexes.¹⁴¹

The object of the Wilks club was to "bring together from time to time during the collegiate year a few congenial men especially interested in the scientific side of medicine and medical education".¹⁴² It was an informal club with no speeches except "talks as might on occasion spring spontaneously from members' brains".¹⁴³ During the life of the association, at least eleven of its members practised in Harley Street. Many of the club's founding members, such as James Andrew, physician to Bart's, and Phillip Henry Pye-Smith, Vice-Chancellor of the London University and physician to Guy's, were also Harley Street men. Although the club did not take on a significant role in advancing medical knowledge, it was, nevertheless, an example of a distinguished group of Harley Street men from various London Hospitals fraternising with their colleagues from the Street. There is no record of a specific Harley Street medical club, but informal clubs like the Samuel Wilks Fifteen Club show evidence of conviviality and social interaction between the Street's medical practitioners.

¹⁴¹ Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980*, (London, 1988), p. 131. See also, Eileen Magnello, *Victorian Values: The Origin of Modern Statistics*, [Cambridge, 2004].

¹⁴² Donkin, *Wilkes*, p. 1.

¹⁴³ Donkin, *Wilkes*, p. 4.

Prominence within Medical Societies

Of the cohort who listed their high-ranking positions in medical societies in the *Medical Directory*, 65 were Presidents and a further 20 were Vice Presidents during their time in Harley Street. Others were appointed to senior positions following their departure from the Street. A number of the cohort were also active in the establishment of these general medical societies: Sir James McGrigor, was one of the founders of the Aberdeen Medical Society (1789)¹⁴⁴; Sir Horatio Bryan Donkin, physician to Westminster Hospital, was a founder member of the Society for Venereal Diseases.¹⁴⁵ George Allan Heron, physician to the city of London Hospital for diseases of the chest, became a principal founder of the London and Counties Medical Protection Society in 1892 and held the position of Treasurer until he was elected President of the Society in 1913.¹⁴⁶

The Royal Society of Medicine (RSM)

One of the most comprehensive London medical societies during the early twentieth century was the Royal Society of Medicine (RSM), which was created following the amalgamation of the RMCS with other specialist societies in 1907. With the growth of specialist hospitals in London, from the mid-to the late-nineteenth century, there was a concomitant rise in the number of specialist medical societies including the Pathological Society (1846), the Epidemiological Society of London (1850), the Odontological Society (1856), the Obstetrical Society (1858) and the Clinical Society

¹⁴⁴ Sir James McGrigor, *The Autobiography and Services of Sir James McGrigor, Bart. Late Director-General of the Army Medical Department*, (London, 1861), p. 6.

¹⁴⁵ Anon, 'Sir Bryan Donkin', *BMJ*, Aug. 6, 1927, p. 240.

¹⁴⁶ Anon, 'George Allan Heron', *BMJ*, Dec. 25, 1915, p. 946.

(1867): many of these societies were absorbed into the RSM once it was established.¹⁴⁷ At the time of the proposed scheme for amalgamation in 1905, 22 out of the 26 societies that had been approached ostensibly represented a “membership of 7000 ... [however] an analysis and comparison of the various lists show that this membership was made up of 4750 *persons*”.¹⁴⁸ Two years later, 26 London medical societies were invited to participate in the emerging comprehensive organization: fifteen responded positively and they were amalgamated to form the “Royal Society of Medicine”.¹⁴⁹

With the increasing number of specialist societies emerging at the end of the nineteenth century, their unification at one geographical location meant attendance was more convenient for medical practitioners who wished to stay informed about developments in various areas of specialist medicine. The Harley Street Area was chosen following

the colonization of Harley Street by the medical profession [which] began at the south end of the street as an overflow from Mayfair and Cavendish Square. Royal appointees made the area fashionable and attracted lesser mortals ... by the early 20th century the area had replaced Mayfair as the base for the medical coterie of London: it was therefore an ideal location for the Royal Society of Medicine.¹⁵⁰

As Hunting further pointed out, the union contained several societies that appealed to specialist interests and “the merger was a landmark in the gradual acceptance of specialization”.¹⁵¹ Additional societies joining in subsequent years included the Society for Study of Diseases in Children and

¹⁴⁷ Hunting, *RSM*, p. 102.

¹⁴⁸ Anon, *RSM*, for a list of the 22 societies see p. cxlii.

¹⁴⁹ Maurice Davidson, *RSM*, pp. 14-22.

¹⁵⁰ Hunting, *RSM*, pp. 179-180.

¹⁵¹ *Ibid.*, p. xix.

the Society of Anaesthetics in 1908. This successful amalgamation of the RSM was co-ordinated by the Harley Street consulting physician to Bart's, Sir William Selby Church.¹⁵²

In 1905, Church, who had ceased to be President of the Royal College of Physicians (1899-1905), became the chairman of the organising committee for the RSM. He was an able negotiator and Sir William Osler, who seconded Church's election, as the RSM's first President, remarked he was, "that rare bird in the profession, a good business man".¹⁵³ Other presidents of the RSM from Harley Street include the physician Sir William Hale-White (1922-23) and the surgeon Vincent Warren Low (President of the RSM in 1932-34, Vice-President of the RCS 1928-1939 and Vice-President of St. Mary's Hospital).¹⁵⁴

Six of the cohort, including Sir Humphry Rolleston and Sir Henry Tidy, were elected to the Presidency of the RSM after they left Harley Street.¹⁵⁵ Rolleston was elected President of the History of Medicine Section (1918-20) and in 1930-31 served as President of the RSM.¹⁵⁶ He was also President of the Medical Society of London (1927), the Association of Physicians (1925 and 1929) and Vice-President of the BMA (1932). Tidy was

¹⁵² This amalgamation had been tried, unsuccessfully, "several times before". Anon, 'Sir William Church, BT', *BMJ*, May 5, 1928, pp. 778 – 780.

¹⁵³ *Ibid.*

¹⁵⁴ Sir William Selby Church, Hunting, *RSM*, Appendix pp. 481- 482 and Anon, 'V. Warren Low', *BMJ*, Sept. 19, 1942, p. 354.

¹⁵⁵ Anon, 'Sir Humphry Rolleston, Bt.' *BMJ*, Sept 30, 1944, pp. 452 – 454. Tidy was President of the RSM in 1942 in addition to senior offices of other medical societies. See Anon, 'Sir Henry Tidy, K.B.E'. *BMJ*, June 18, 1960, pp. 1896-97. The other four were Viscount Dawson of Penn (1928-1930), Sir William Girling Ball (1938 –40), Sir Henry Letheby Tidy (1942-44) and Sir Gordon Gordon –Taylor (1944 – 46).

¹⁵⁶ Hunting, *RSM*, p. 199.

appointed Physician-in-Ordinary to the Duke of York (later King George VI) in 1936 and in 1952 became Extra-Physician to The Queen. In 1942 he was elected President of the RSM and also chaired International Conferences at the Society.¹⁵⁷

The Pathological Society of London ¹⁵⁸

The societies, which joined the RSM and attracted the greatest number of members from the cohort were the pathological and clinical societies. Beginning in the 1850s, collaboration amongst those with particular specialist interests and a desire to inform, educate and disseminate the rapidly expanding specialist knowledge, gave rise to a number of specialist societies such as the Pathological Society of London (1846). In the last Presidential address of the Society before it was absorbed by the RSM in 1907, Philip Henry Pye-Smith the Harley Street consulting physician to Guy's Hospital, remarked:

when our Society was founded pathology was still the hand-maid of Medicine and Surgery as is shewn by the names I have cited. The science has now a far more independent position, and is the foundation or *institute* on which all scientific prevention and treatment of disease must rest.¹⁵⁹

The practice of pathology as a branch of medicine dates back to William Harvey (1578-1657) whose own "anatomical lectures contain[ed] many allusions to his own observations in morbid anatomy".¹⁶⁰ By the mid-

¹⁵⁷ J. M. H. Moll, *Presidents of the Royal Society of Medicine*, (London, 1996), p. 300. Other Presidents who were in Harley Street were Sir Girling Ball (1938-1940),

¹⁵⁸ There was also another pathological society established in 1906, which met bi-annually called the Pathological Society of Great Britain and Ireland. This society's mouthpiece was the *Journal of Pathology and Bacteriology*, which had been founded in 1893.

¹⁵⁹ Quoted in J. Henry Dible, *A History of the Pathological Society of Great Britain and Ireland* (Edinburgh, 1957), pp. 3-4.

¹⁶⁰ W. D. Foster, *Pathology as a Profession in Great Britain and the Early History of the Royal College of Pathologists*, (London, no date probably circa 1970s), p. 1. William Harvey

1820s, the study of pathology had become an essential part of the medical curriculum and by 1831, British medical schools began to employ professors of pathology.¹⁶¹ The Pathological Society was established in 1846 for the “cultivation and promotion of Pathology, by the exhibition and description of Specimens, Drawings, Microscopic Preparations, casts, or Models, of Morbid Parts”.¹⁶² Its aim was to promote an interest, initially in morbid anatomy (though later other branches of pathology were added) and to encourage a more concrete approach to medical studies, which had hitherto, according to the society, been too abstract. The Society’s rules “specifically banned ‘speculative argumentation or discussion’ at meetings”.¹⁶³ Papers presented at the society were recorded periodically in *Transactions of the Pathological Society of London*.

Two of the twenty members of Council, who managed the affairs of the Society, Richard Quain and George Busk, were from Harley Street.¹⁶⁴ Only a few of the original members in 1846 were Harley Street men, but later membership lists show an increasing number from the Street.¹⁶⁵ Apart from the BMA and the RSM, the Pathological Society had the greatest number of members from the male cohort: 107 members and eight fellows

discovered the circulation of the blood, up to this time physicians accepted Galenic physiology in which the heart did not pump blood around the system, for an explanation of Harvey’s theory, See, Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present*, (first published 1997, this edition London, 1999), p. 211-216.

¹⁶¹ Foster, *Pathology*, pp. 2-4.

¹⁶² Anon, *Transactions of the Pathological Society of London*, (London, 1848), p. 15.

¹⁶³ *Ibid.*

¹⁶⁴ Anon, *Pathological Society*, p. 7

¹⁶⁵ *Ibid.*, pp. 7-14, only one member, William McIntyre was listed as practicing in Harley St., but three other members Alfred Garrod, William Jenner and Edmund Alexander Parkes would later move to the Street.

were Harley Street practitioners and a number of these played a prominent role within the society and in the development of pathology as a subject.

The Clinical Society of London

The Clinical Society, founded in October 1867 in Queen Anne Street, was part of the wave of specialist societies that appeared in the late nineteenth century. It was established in the belief that insufficient attention was paid to the discussion and exhibition of living cases.¹⁶⁶ Thus, the purpose of the society was for the “cultivation and promotion of practical medicine and surgery, by the collection of cases of interest, especially of such as bear upon undetermined questions in Pathology or Therapeutics”. Invitations to join the society were sent to members of staff of recognised London hospitals and medical schools.¹⁶⁷

The society planned to support physicians and surgeons who believed in the actual observation and treatment of patients, who endorsed practical medicine over theoretical or investigational methods. The clinicians were so strongly opposed to academic discussions on general topics that they allotted just ten minutes for such discussions. Instead, they concentrated their efforts on presenting patients together with their case histories.¹⁶⁸ Reports of these were occasionally published; however, this was abandoned when the society amalgamated with the RSM in 1907. Members of the Clinical Society from Harley Street included distinguished men such as Morell Mackenzie,

¹⁶⁶ Crawford, ‘Medical Societies’, p. 14.

¹⁶⁷ Anon, *Transactions of the Clinical Society of London*, vol. 1, (London, 1868).

¹⁶⁸ Hunting, *RSM*, p. 106.

Vincent Warren Low, William Hale-White, Dawson Williams and Charles Alfred Ballance.

Societies founded by Harley Street men which merged with the RSM

Peterson found that the first specialist medical society emerged in the 1820s. Whilst a number were established after the middle of the nineteenth century, the "great era" of specialist societies was the 1880s when, according to Peterson, six new societies were formed.¹⁶⁹ In the last quarter of the nineteenth century, a number of Harley Street men on the staff of specialist hospitals were instrumental in the foundation of new medical societies. Alfred Herbert Tubby's work on diseases in children at the Evelina Hospital for Sick Children prompted him, together with Stephen Stephenson, to establish the Society for the Study of Disease in Children in 1900, which had 102 original members. The focus for the society was for "the more exact and scientific study of disease in childhood".¹⁷⁰ By 1904, society membership had risen to 304. When the society was amalgamated with the RSM in 1907, Tubby was appointed President of the Section for a term.¹⁷¹

Advancements in Dermatology in the late nineteenth century were due largely to a number of Harley Street men who were also prominent in the Dermatological Society of London established in 1882 and the Dermatological Society of Great Britain and Ireland founded in 1894. Phineas Simon Abraham a consultant dermatologist to the West London Hospital and to the Hospital for Diseases of the Skin, Blackfriars, was

¹⁶⁹ Peterson, *Medical Profession*, p. 266.

¹⁷⁰ Peterson, *Medical Profession*, p. 310.

¹⁷¹ Anon, 'Alfred Herbert Tubby', *BMJ*, 1930, March 1, p. 419.

together with Erasmus Wilson (a non Harley Street practitioner) one of the founders of the Dermatological Society of Great Britain and Ireland. Abraham was also instrumental in establishing the Royal Academy of Medicine of Ireland.¹⁷² At the 1910 London meeting of the BMA, Abraham was elected President of the section of Dermatology and had been President of the West London Medico-Chirurgical Society in the previous year.¹⁷³ The Society included specialists and GPs who were interested in dermatology.

Following the foundation of the RSM, these two dermatological societies merged to form the Section of Dermatology. Its founder members and the Section's first three Presidents were the Harley Street dermatologists, Henry Radcliffe Crocker, Malcolm Alexander Morris and Thomas Calcott Fox. Crocker was elected in 1907 with Dr Arthur Whitfield another Harley Street man, who acted as one of the two secretaries. Crocker had also been a founder member of the Dermatological Society and much of the Section's early success has been attributed to his enthusiasm and energy.¹⁷⁴ Thomas Calcott Fox succeeded Crocker as President on his death in 1909 and remained in office until 1911 when Sir Malcolm Morris was nominated.

Morris was also a prolific writer and was active in developing the *Journal of Dermatology*.¹⁷⁵ His position as medical editor of Cassell and Company in the 1880s, in addition to being a member of the board in 1906

¹⁷² Anon, 'Phineas Simon Abraham', *BMJ*, March 12, 1921, p. 406.

¹⁷³ *Ibid.*

¹⁷⁴ Anon, 'Henry Radcliffe Crocker' *BMJ*, Sept. 11, 1909, p. 729 and Council Minutes of the Section of Dermatology 31 May 1910, quoted in Hunting, *RSM*, p. 258.

¹⁷⁵ Anon, 'Sir Malcolm Morris', *BMJ*, March 1, 1924, p. 407.

and editor of the journal *Practitioner* from 1895 to 1902, meant his contacts were extensive.¹⁷⁶ In 1883, he edited the *Book of Health* that included contributions from a number of his Harley Street colleagues, including James Cantlie. Morris, who was also co-editor of the *International Journal of Medical Science* and President of the Dermatological Section of the International Congress, London 1913, was both socially and professionally a leading figure in the world of medicine and was awarded the KCVO in 1908, in recognition of his professional services to King Edward VII.

Alfred Herbert Tubby, orthopaedic surgeon to the Westminster Hospital and the Royal National Orthopaedic Hospital, was instrumental in the foundation of the Society for the Study of Disease in Children and played a large part in establishing the British Orthopaedic Society. This society lasted only a few years and was superseded in 1918 by the British Orthopaedic Association.¹⁷⁷ One of this Association's founders, Sir Thomas Arthur Harold Fairbank an eminent orthopaedic surgeon, was later elected as the Association's President (1926-27).¹⁷⁸ Fairbank was an active proponent of orthopaedic surgery as a speciality, and helped to raise its profile in the medical arena when he became President of the Orthopaedic section of the RSM.

Increasing interest in neurology and neurosurgery in the late nineteenth century gave rise to the establishment of a society to discuss advances in the field. The Neurological Society of London was set up in 1886

¹⁷⁶ *Ibid.*

¹⁷⁷ Anon, Tubby', *BMJ*, p. 419.

¹⁷⁸ *Ibid.*

to cater for this medical speciality. The name of the society was changed in 1903 to the Neurological Society of the United Kingdom to reflect the number of attendees from outside London. The Harley Street physician, Charles Edward Beevor was the last President of the society prior to its merger with the RSM in 1907. Beevor, who specialised in neurology, published the results of his extensive clinical and experimental research with Sir Victor Horsley on muscular movements and their place in the nervous system. This publication led to him becoming "one of the recognised neurological authorities in the country".¹⁷⁹ He further enhanced his reputation with his 1908 paper on the arterial supply to the brain, which was the first time that this had been described in print.¹⁸⁰

Another Harley Street neurologist, Henry Head who had been instrumental in directing the merger negotiations of the society (1905-1907) with the RSM, was appointed President of the Neurological Section in 1918.¹⁸¹ A number of Harley Street physicians such as Alexander Hughes Bennett, Gordon Morgan Holmes, Edward Farquhar Buzzard, Samuel Alexander Kinnear Wilson and Wilfred Trotter were active members of the society and contributed regularly to the society's associated publication *Brain*.¹⁸² Leslie J. Paton was President of the Neurological Section of the RSM in 1931 and was also President of the Ophthalmological Society of the

¹⁷⁹ Anon, 'Charles Edward Beevor', *Lancet*, Dec. 19, 1908, p.1854

¹⁸⁰ The Paper was published in the Philosophical Transactions of the Royal Society of London, and later published as a book. *Ibid.*, and Anon, 'Charles Edward Beevor', *BMJ*, 12 Dec, 1908, p. 1785.

¹⁸¹ Hunting, *RSM*, p. 265.

¹⁸² Bennett contributed an article on diseases of the nervous system to almost every volume of *Brain* in the 1880s, Anon, 'Alexander Hughes Bennett', *BMJ*, Nov. 9, 1901, p. 1444.

United Kingdom. In 1934, he was President of the Section of Ophthalmology at the BMA and had been Treasurer of the International Ophthalmological Council.¹⁸³

Three of the 15 founder members of the British Proctology Society, established in 1912, were Harley Street men and two, Charles Ryall and Frederick Swinford Edwards, went on to become Presidents following the Society's amalgamation with the RSM in the following year. Edwards became the section's first President (1913-1919 and in 1924-1925).¹⁸⁴

A short-lived Obstetrical Society (c1825-1830) was set up by Dr Augustus Granville to canvass the medical corporations to introduce a system of regulation for midwifery, which was essential because of the number of unqualified medical practitioners.¹⁸⁵ To provide a meeting place for the discussion of subjects relating to obstetrics, a new Obstetrical Society was established in 1858, under the chairmanship of Dr Edward Rigby. Before he arrived in Harley Street in 1879, the eminent obstetrician Robert Barnes was also one of the society's principal founders.

Twenty-six years later, on 27 December 1884, Barnes called for a resolution, "that a Gynaecological Society be now founded to be called the British Gynaecological Society".¹⁸⁶ The resolution was passed and the society was established with the aim "to promote the science & art of

¹⁸³ Anon, 'Leslie J. Paton', *BMJ*, June 12, 1943, p. 741.

¹⁸⁴ Hunting, *RSM*, pp. 369-370.

¹⁸⁵ See Jean Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, (London, 1988).

¹⁸⁶ Anon, 'Robert Barnes', *BMJ*, May 18, 1907, pp. 1221-22.

gynaecology".¹⁸⁷ The Obstetric and the Gynaecological Societies functioned until 1907 when they were absorbed into the Obstetric and Gynaecological Section of the RSM.¹⁸⁸ The Harley Street obstetric physician to the London Hospital, George Ernest Herman was an active fellow of the Obstetrical Society of London and was President from 1893-95.

Of the 27 original London members of the Laryngological Society of London founded in 1893, seven were Harley Street practitioners and a further 12 practised in the surrounding streets such as Wimpole Street and Queen Anne Street.¹⁸⁹ Others such as Atwood Thorne held high-ranking positions when the society merged with the Rhinological and Otological Societies. Thorne was Vice-President of the Association and later secretary of the Laryngological Section of the RSM. Whilst most of the original members were based in the Harley Street and were involved in the development of the speciality such as Sir Henry Trentham Butlin, who was President of the Laryngological Society (1897-98).

Sections of the RSM and Harley Street men

A number of the cohort held high-ranking positions in the sections of the RSM and some of these will be discussed below. The Balneological and Climatological Section of the RSM was established in 1909; its forerunner

¹⁸⁷ *Medical Directory*, 1899, p. 477.

¹⁸⁸ Hunting, *RSM*, p. 106.

¹⁸⁹ There were also some members from the provinces. Anon, *Proceedings of the Laryngological Society of London*, Vol. 1, 1893-94 (London, 1895) pp. v-vi. There were also 13 Country members. Other founding members such as William Stewart (1852-1906), surgeon to London Throat Hospital had previously practised in Harley Street. See Anon, 'William Robert Henry Stewart', *BMJ*, 1906, Apr. 7, 1906, p.837.

had been created in 1895 and by 1905 had a membership of 380.¹⁹⁰ Balneology, the medical study of bathing and climatology the scientific study of climatic conditions, was of considerable interest to the Victorian and Edwardian medical profession.¹⁹¹ Leonard Williams who had been editor of the *Journal of Balneology and Climatology* and Vice-President of the British Balneological and Climatological Society, was appointed as the first President of this section of the RSM. His fluency in French and German was useful in building up a considerable knowledge of Continental spas.¹⁹² Other Presidents included Sir Charlton Briscoe physician to King's College Hospital whose main interest was in respiratory disease. He was President of the Section of Medicine from 1935 to 1937.¹⁹³

Raymond Crawford played an active role along with (the non-Harley Street) Sir William Osler in establishing the History of Medicine Section of the RSM in 1912. Following Osler's retirement in 1916, Crawford, who had written a number of historical books including, *The King's Evil* and *Echoes of Pestilence in Literature and Art*, became the section's second president and held this position until 1918.¹⁹⁴

¹⁹⁰ Hunting, *RSM*, pp. 316-17. Caroline Murphy discusses the role of balneology in cancer patients during the period in 'Cancer and radiotherapy in Britain: 1850-1950, (PhD thesis, UMIST, 1986).

¹⁹¹ *Ibid.*, Other Harley Street practitioners who were interested in the subject include Robert Fortescue Fox, who for many years edited the *Medical Directory's* section on health resorts. Anon, 'Robert Fortescue Fox', *Lancet*, June 22, 1940, p. 1141.

¹⁹² Anon, 'Leonard Williams', *BMJ*, Aug. 26, 1939, p. 472.

¹⁹³ Anon, 'Sir Charlton Briscoe', *BMJ*, March 5, 1960, p. 733.

¹⁹⁴ Anon, 'Sir Raymond Crawford', *Lancet*, Mar. 19, 1938, p. 697 and Hunting, *RSM*, p. 330. Sir Raymond Crawford's supplemented his extensive contributions to medical literature by his historical work. Crawford's account of the *Last Days of Charles II*, (1909) reviewed the reports of the medical practitioners in attendance at the King's death and concluded that his death was a result of convulsions probably caused by Gout.

In addition to being President of the Orthopaedic Section, Sir Thomas Fairbank was also President of the Paediatric Section.¹⁹⁵ Hugh Lloyd Williams was President of the Odontological Section from 1911-12 and was elected Vice-President of the RSM in the following year. Others included Malcolm Langton Hepburn who was Vice-President (1912-1933) and later President of the Ophthalmological Section (1938-1940).

In 1920, Sir Peter Freyer, surgeon to St. Peter's Hospital for Stone was elected President of the newly formed Section of Urology. Freyer had published a number of books on urological surgery and received the Arnott Memorial medal for his original research in his speciality in 1904. He built a large consulting practice in Harley Street and several of his articles in medical journals drew on the experience garnered from his practice such as "1000 Cases of Total Enucleation of Prostate for Radical Cure of Enlargement of that Organ".¹⁹⁶ Sir Thomas Horder was elected one of the section's two Vice-Presidents and in October delivered the first paper 'On the treatment of subacute nephritis by kidney decapsulation'. Other Harley Street medical practitioners such as the urologist Cyril Nitch and the gynaecologist Victor Bonney were also present at the first session.¹⁹⁷

Herbert James Marriage, aural surgeon at St. Thomas's Hospital, was President of the Otological Section in 1915 and had been secretary of the section of Otology at the annual meeting of the BMA in London in

¹⁹⁵ Anon, 'Sir Thomas Fairbank', *BMJ*, March 11, 1961, pp. 751 – 52.

¹⁹⁶ Anon, 'Sir Peter Johnston Freyer', *Lancet*, Sept. 24, 1921, pp. 677-678.

¹⁹⁷ Hunting, *RSM*, p. 351.

1910.¹⁹⁸ Edward David Darlean Davis, a specialist in ENT surgery at Charing Cross Hospital, was President of the Otological and Laryngological sections of the RSM.¹⁹⁹

Not all societies were keen to be engulfed by the RSM, some preferred to retain their independence. Walter Hamilton Hylton Jessop, senior ophthalmic surgeon to Bart's and a Harley Street practitioner, was one of the chief opponents to the proposal for the amalgamation of the Ophthalmological Society of the United Kingdom with the RSM in 1907. Jessop's role in maintaining the individuality of the society was rewarded in 1915 when he was elected President, "an honour which he valued more than any that could have been conferred upon him".²⁰⁰ An independent section of Ophthalmology was later established at the RSM in 1912 with the Harley Street practitioner, Sir George Anderson Critchett, as its first President. Jessop's desire to further the knowledge of British ophthalmology abroad meant he attended most of the International Congresses on ophthalmology and was a member of the Belgian, Spanish and American Ophthalmological societies. He also worked assiduously in Britain to establish an all-encompassing *Journal of Ophthalmology*, which absorbed the *Royal London Ophthalmic Hospital Reports*, the *Ophthalmic Review* and the *Ophthalmoscope*.²⁰¹

¹⁹⁸ Anon, 'Herbert James Marriage', *BMJ*, Jan. 26, 1946, pp. 148-149.

¹⁹⁹ Anon, 'E. D. D. Davis', *BMJ*, 27 March, 1976, p. 776.

²⁰⁰ Andrews, et al., *Bart's*, p. 2.

²⁰¹ Anon, 'Walter Hamilton Hylton Jessop', *Lancet*, Feb. 24, 1917, p. 310.

Other Specialist Societies and Harley Street men

When Patrick Manson (1844-1922) invited the Harley Street surgeon, James Cantlie to Hong Kong in 1887 Cantlie gained his knowledge of tropical diseases in his surgical practice during the plague epidemic in Canton in 1894.²⁰² On his return to London, he resolved to establish a school of tropical medicine, to publish a journal on tropical diseases and called for a section on tropical diseases at the BMA. In 1898, the council of the BMA concurred and the section was formed with Sir Patrick Manson as its first President. Cantlie was a founder member of the Society (later Royal) of Tropical Medicine and Hygiene (1907).²⁰³

William Carnegie Brown, another Harley Street physician who specialised in tropical disease also played an important part in the formation of the society and was appointed one of society's first two secretaries. J. Mitchell Bruce, a boyhood friend of Cantlie. Bruce, a fellow Harley Street practitioner and consulting physician to Charing Cross Hospital, referred to Cantlie as, "essentially an inventor, certainly a pioneer in things great and small" and Cantlie was described in his obituary as "an outstanding figure in the medical field".²⁰⁴ Cantlie retained such close connections with China that when one of his ex-students Sun Yat-Sen

²⁰² Manson was a fellow Scot, a surgeon and a leading expert in Britain on tropical diseases, in particular malaria. He was the driving force in the establishment of the London School of Tropical Medicine and was also the first President of the Society of Tropical Medicine. See Philip Manson-Bahr, 'Patrick Manson: Father of tropical medicine', in *British Men of Science Series*, Sir Gavin de Beer, (ed.), (London, 1962).

²⁰³ Lise Wilkinson and Anne Hardy, *Prevention and Cure: The London School of Hygiene & Tropical Medicine: A 20th Century Quest for Global Public Health*, (London, 2001), pp. 19, 334-5. See also Jean Cantlie Stewart, *The Quality of Mercy: the Lives of Sir James and Lady Cantlie*, (London, 1983). See also, Anon, 'William Carnegie Brown', *Lancet*, Oct. 11. 1913, p. 1090.

²⁰⁴ Anon, 'Sir James Cantlie', *BMJ*, June 5, 1926, pp. 971-972.

(1866-1925) came to London, he stayed with him in Harley Street. Yat-Sen was a key figure in the defeat of the Ching dynasty in China and later became the first President of the Republic of China. In 1896 while Yat-Sen was in Harley Street, Ching sympathisers kidnapped him and sparked a diplomatic crisis. Cantlie secured his release with the help of the Foreign Office.²⁰⁵

Conclusion

The constellation of social and professional interchanges amongst medical professionals, made possible through lectures, orations and societies, could enhance their reputations within the profession, especially something as prestigious as the Harveian Oration, which was reported in the *BMJ*, the *Lancet* and national newspapers.²⁰⁶ Given the tumultuous technological changes during Victorian Britain and the rapid speed at which they occurred, Victorian society looked for ways to ease the tension and instability as a consequence of the transformations of their culture by inventing “new” traditions and creating rituals in their orations and lectures. Yet, it was to be the professional medical societies, which offered these medical practitioners social cohesion. As Sir Humphry Rolleston remarked,

medical societies offer[ed] a legitimate means of intra-professional advertisement, and so enable[d] young men, living, however, mainly on hope, to make themselves known to their older, better established, but not necessarily better equipped, brethren.²⁰⁷

²⁰⁵ Thomas Chen and Peter S Y Chen, ‘The accomplishments of Sir James Cantlie’, *Journal of Medical Biography*, Vol. 7, Number 4, Nov, 1999, p.198.

²⁰⁶ A. M. Cooke, *Sir E. Farquhar Buzzard, Bt. K.C.V.O., D.M., F.R.C.P. An Appreciation* (London, 1975), p.11

²⁰⁷ Rolleston, ‘Medical Friendships’, p. 263.

A sense of community spirit was greatly facilitated by the geographical location of Harley Street, which was in close proximity to many of the medical and scientific societies in London. Meeting and interacting with some of their medical neighbours, as well as other medical practitioners, created an essential physical space for the development of the professionalisation and specialisation of medicine at the end of the 19th century.

CHAPTER 6

Professional Advancement and the Transmission of Medical Knowledge — Medical Publications

This chapter will examine the dissemination of medical knowledge via medical publications. The number of journals to which the Harley Street practitioners contributed was extensive — as was the wide range of their society memberships. Thus, I argue that these men were more prodigious in their publications than other medical practitioners in London and throughout Great Britain during the same time-period. As will be seen, Harley Street practitioners wielded considerable collective editorial authority in their role as editors of a wide range of medical journals, hospital reports, manuals and dictionaries such as Clifford Allbutt and Humphry Rolleston's *A System of Medicine* and Richard Quain's *Dictionary of Medicine*. Moreover, three generations of Harley Street men, William Markham, Ernest Hart and Dawson Williams, were editors of the *British Medical Journal* whose editorial input spanned nearly seven continuous decades of influence. In addition, the *Medical Press and Circular* was in editorial control of Harley Street men at various times for nearly six decades. Finally, there were at least 38 (6 per cent) other members of the cohort, who were editors of medical or scientific journals or hospital reports, some of which they founded.

The percentage of the cohort who had a) published at least one article in a scientific journal or hospital report, b) published in the *BMJ* or the

Lancet or c) who published an article or a book was assessed. The publication of textbooks, manuals, handbooks, guides and student lecture notes by the group was also considered.¹ The results were then compared to the proportion of medical practitioners in Britain who had also published material.²

Concomitant with the rise of medical societies in nineteenth century Britain was an increase in the number of medical publications. Although the Royal Society had published medical papers in its *Philosophical Transactions* since 1662, it was not until the eighteenth century, with the development of medical clubs and societies, that other associated journals catered specifically for the medical market. The Victorian period witnessed a proliferation of these medical and scientific journals; some were published in association with medical societies whilst others were run on a commercial basis. Prior to these publications, the various methods of publishing one's research findings were through books, pamphlets, correspondence, or by giving a lecture.³

Medical textbooks, written by the lecturers from the main London teaching hospitals along with the publication of hospital reports, reflected the rise of the hospital as the locus of medical education in the nineteenth century. Some of the earliest medical reports to appear were from Guy's

¹ The *Medical Directory* did not provide a complete list of the cohorts' publications and in some cases omitted their publications altogether. Whenever possible other sources such as obituaries and biographies were used to supplement the *Directory*.

² The results were compared to Anne Digby's analysis in, *The Evolution of British General Practice, 1850-1948*, (Oxford, 1999), pp. 6 and 217-218, including graph on page 218.

³ Sir Humphry Rolleston, 'Medical Friendships, Clubs and Societies', *Annals of Medical History*, Vol. 2, May, 1930, Number 3, pp. 257-58.

Hospital and St Thomas's Hospital in 1836. Other teaching hospitals, such as St Bartholomew's followed with publications of their own from 1865. The rise of the specialist hospitals such as the London Ophthalmic, beginning in the middle of the nineteenth century, continued this sponsorship of in-house hospital reports.⁴ As discussed in Chapter Three, the granting of prizes for essays on medical matters and the creation of new ones such as the Carmichael Prize encouraged ambitious students to have their work published.⁵

Such publications displayed medical knowledge and also attention from the senior members of the hospitals — an important consideration in the development of a medical career. As Peterson remarked, "reputation, built on visibility as well as sound achievement, could be found in the burgeoning industry of professional publication".⁶ R. Scott Stevenson, a Harley Street oto-laryngologist who was also sub-editor of the *BMJ* in the 1920s, argued that journals were "indispensable to the progress of medicine". He referred to the medical advances such as those made by Lister and Mackenzie that had been brought to the attention of the medical profession through accounts in medical journals.⁷

Various historians have endeavoured to determine the total number of British scientific periodicals published in the nineteenth century.

⁴ M. Jeanne Peterson, 'Medicine' in J. Don Vann and Rosemary T. Van Arsdell, (eds.), *Victorian Periodicals and Victorian Society* (Toronto, 1994), p. 28.

⁵ First awarded in 1887 by the Council of The Royal College of Surgeons in Ireland.

⁶ M. Jeanne Peterson, *The Medical Profession*, (London, 1978), p. 172.

⁷ Lister's accounts of his surgical case studies were published in the *BMJ* and Mackenzie's work on the pulse and the heart were published in *BMJ* and *Lancet*. See R. Scott Stevenson, *In a Harley Street Mirror* (London, 1951), p. 6.

Between 1824 and 1900, these were listed in *The Waterloo Directory of Victorian Periodicals*.⁸ William Brock found there were 535 periodicals and Jeanne Peterson calculated that there were 458 medical periodicals.⁹ Excluding periodicals founded before the nineteenth century, Bill Bynum and Janice Wilson computed the number of new medical publications established from 1800 to 1899 as 479.¹⁰ In addition to the transactions of the scientific societies such as the Royal Society and the Linnean Society, which were interested in certain medical ideas, by the 1840s there were also transactions of medical societies, including the Royal Medical Society of Edinburgh and the Provincial Medical and Surgical Association whose organ was the *Provincial and Surgical Journal*. Apart from journals affiliated to societies, independent medical journals such as the *Lancet* were set up as a forum for debate and published for profit.

Many of the Victorian periodicals were of such an ephemeral nature that Jean and Irvine Loudon found that of the 168 periodicals established between 1800 and 1849 only 12 survived to 1900.¹¹ Bynum and Wilson showed that Victorian medical periodicals were not standardized, but varied in their layout, frequency of publication and the focus for their intended

⁸ Michael Wolff, John S. North and Dorothy Deering, *The Waterloo Directory of Victorian Periodicals: 1824-1900*, Phase I, (Waterloo, Ont., 1976).

⁹ W. H. Brock 'Medicine and the Victorian Press' in W.F. Bynum, Stephen Lock and Roy Porter, *Medical Journals and Medical Knowledge, Historical Essays*, (London, 1992), p. 71. Peterson, 'Medicine', p. 29.

¹⁰ W. F. Bynum and Janice C. Wilson 'Medicine and the Victorian Press' in Bynum et al, *Medical Journals*, p. 30.

¹¹ Jean Loudon and Irvine Loudon 'Medicine, Politics and the Medical Periodical 1800-50' in Bynum et al, *Medical Journals*, p. 49.

subscribers.¹² Weekly publications included the *Lancet*, *The Provincial Medical and Surgical Journal* and the *Medical Times*.¹³ The frequency of publication times varied from the weekly issue of *The Medical Press and Circular* to an annual report for the *Medico-Chirurgical Transactions*. To analyse the disparate publications, Bynum and Wilson classified them into these five broad groups: general periodicals, specialist periodicals, scientific journals, journals on health and related topics for the general public and unorthodox journals. The first two categories: general periodicals “were aimed at the whole of the medical profession” and “specialist periodicals the principal readership of which would have been some group within the profession” are of particular interest in this thesis.¹⁴ The second group included publications that were specifically aimed at general practitioners.

Anne Digby found from her sample of 961 British GPs between 1850-1948, that beginning in the 1850s, they were “active in clinical investigation and in disseminating their findings” and that up until the 1900s, more than 40 per cent had published, but after this date the number declined to just over 20 per cent.¹⁵ Irvine Loudon examined publications by physicians only. He calculated the number who had published material from a sample of 2000 physicians randomly selected from the *London and Provincial*

¹² Bynum and Wilson, ‘Periodical Knowledge: Medical Journals and their Editors in Nineteenth-Century Britain’ in Bynum et al, *Medical Journals*, pp. 29-48.

¹³ In 1852, the *London Medical Gazette* (established in 1827) merged with the *Medical Times* (established in 1839) and was renamed *Medical Times and Gazette*. Peterson, ‘Medicine’, p. 24, footnote.

¹⁴ Bynum and Wilson, ‘Periodical Knowledge’, p. 32.

¹⁵ Digby, *General Practice*, pp. 6 and 217-218, and graph on p. 218.

Directories for the year 1847 and found that approximately 50 per cent had published work.¹⁶

Whilst Digby and Loudon showed that up to 50 per cent of GPs and physicians published material, Harley Street practitioners were more prolific, since *at least* 85 per cent ($n = 558$) of these published their work.¹⁷ They contributed articles to medical or scientific journals, prepared hospital reports or published books before or during their arrival in Harley Street. Additionally, the majority of the group (68.34 per cent, $n = 449$) contributed articles to a wide range of medical or scientific journals. Thus, in contrast to Digby's sample of general practitioners or Loudon's sample of physicians, Harley Street medical practitioners were highly active in disseminating the results of their clinical investigations and circulating their medical knowledge within the medical and scientific community. As a contributor to the *BMJ* remarked, "many leading men are content to put after their names: 'contrib. to med. journals,' many of the younger members give specific details of their contributions".¹⁸ Almost 70 per cent of the entire cohort (or 80 per cent of those who published) contributed specifically to various medical journals and hospital reports, which was an indication that they were in this category of leading men.

¹⁶ Irvine Loudon, 'Two thousand Medical Men in 1847', *Bulletin of the Society for Social History of Medicine*, 1983, p. 7. Quoted in Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, (Cambridge, 1994), p.192.

¹⁷ This number who published is likely to be higher given the omissions in the *Medical Directory* mentioned in Chapter 1.

¹⁸ "The *Medical Directory*", *BMJ*, 9 Aug., 1902, Vol. 2, p.426, quoted in Marguerite W. Dupree and M. Anne Crowther, 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: The *Medical Directory* as a Historical Source', *Bulletin of the History of Medicine*, Vol. 65, 1991, p. 214.

In contrast to Digby's figures, the number of publications for the Harley Street group did not decrease over time. Indeed, those who did *not* publish before or during their time in Harley Street ($n = 99$, 15 per cent) were not, in general, eminent medical men.¹⁹ Publication was intrinsically linked to eminence within the Harley Street group. Digby also noted that most of those who held MDs wrote on the subject of their dissertations: the results of her analysis showed that there was a relationship between publication and the higher medical degree.²⁰ That is, those who held an MD were more likely to publish than those with a lower educational qualification such as an MB. Approximately a third of her cohort who held MDs published something between 1820-1939.²¹ The percentage of Harley Street practitioners who had received their MD before or during their time in Harley Street and who had published was more than three times greater than in Digby's study: of the Harley Street group who had MDs, 93 per cent published some aspect of their work.

There are a number of reasons for the productivity of the Harley Street group. As has been already mentioned, publication in the popular medical journals such as the *BMJ*, the *Lancet* or the *Practitioner* could gain the attention of the senior hospital staff, and in the competitive medical market, this was a useful adjunct to one's medical qualifications in lieu of

¹⁹ The exception was James Chambers who did, in fact, publish though not until his departure from Harley Street. Chambers was an assistant editor of the *Journal of Mental Science* from 1900-1905, see, Anon, 'James Chambers' *BMJ*, June 18, 1938, p. 1, 342. Of those who had not published, none had an obituary in *Lancet* or the *BMJ*, Francis Bisset Fitton was the only FRCP the others were mainly general practitioners.

²⁰ Digby, *General Practice*, pp. 216-218.

²¹ *Ibid.*, p. 218.

the Royal Colleges' veto on advertising. Another reason was that many of the cohort were interested in promoting a particular or special area of medicine and their publications reflected this. For example, most of William Henry Corfield's extensive publications were concerned with hygiene, sanitation and public health.²² Consequently, Corfield was appointed Professor of Hygiene at UCL — the first chair of its kind in London. Only a minority of the cohort, such as the surgeon Frederick William Forbes Ross wrote on a wide variety of medical topics. Forbes Ross' contributions ranged from researches into tuberculosis, cancer and diseases of the nose, mouth, throat and larynx.²³

Digby found that there was an increase in the number of GPs who submitted at least one article to the *BMJ* or the *Lancet* from the 1850s onwards. She further established that contributions were marginally more common in the *BMJ* than the *Lancet*.²⁴ It was difficult to determine the *maximum* number of Harley Street practitioners who contributed to either the *Lancet* or the *BMJ*, as many of the records in the *Medical Directory* were entered as contributions to "various journals". Further investigation in such sources as obituaries and biographies revealed that some of these contributions were to the *BMJ* or the *Lancet*, but it would be difficult to determine this in each case.²⁵ Publications from those who specifically mentioned the *BMJ* or the *Lancet* were, however, analysed. This analysis

²² For details of his many publications, see Anon, 'William Henry Corfield', *BMJ*, Sept. 12, 1903, p. 627.

²³ Anon, 'F. W. Forbes Ross', *BMJ*, Sept. 27, 1913, p. 834.

²⁴ Digby, *General Practice*, p. 217.

²⁵ As stated in Chapter One, obituaries were available only for 52 % of the cohort.

revealed that in contrast to Digby's GPs, the Harley Street practitioners published more frequently in the *Lancet* ($n =$ at least 254) than in the *BMJ* ($n =$ at least 194).

Given the Victorian convention for publishing anonymously or using a pseudonym or initials, the total figure for those in the group who published would undoubtedly have been greater if it were possible to identify these individuals.²⁶ Many of the physician Henry G. Wright's contributions to the *Lancet*, which were frequently instructive or sardonic, were unsigned and fell under the heading of "annotations".²⁷ Another physician, John Thompson Dickson, a lecturer in mental diseases at Guy's Hospital contributed to a variety of journals; he also wrote a series of controversial articles for the *BMJ*, which were titled "A Social Blot". Though his comments were published anonymously, his obituarist stated they had erroneously been attributed to a number of other authors.²⁸ The names of those who were commissioned to write articles or reviews for the *BMJ* in the Victorian or Edwardian period were not revealed and the leading articles in the *Lancet* were unsigned.²⁹ As Bynum and Wilson discerned, even the name of the editor or those on the editorial board was often obscure.³⁰

²⁶ Paul Vaughan, *Doctors' Commons, a Short History of the British Medical Association*, (London, 1959), p. 137. Vaughan stated that many of the articles in the *BMJ* were anonymous.

²⁷ Anon, 'Henry G. Wright', *BMJ*, Jan. 16, 1869, p. 62.

²⁸ Anon, 'Death of a Physician in his Carriage', *BMJ*, Jan. 10, 1874, p. 52 and Anon, 'John Thompson Dickson' *BMJ*, Jan. 17, 1874, p. 94.

²⁹ P. W. J. Bartrip, *Mirror of Medicine: the BMJ 1840-1990*, (Oxford, 1990), p.75

³⁰ Bynum and Wilson, 'Periodical Knowledge', p. 42.

Articles in Medical Societies' Transactions

Publications provided the cohort with a forum for challenging accepted medical practices, for communicating new theories or the results of experimental work and for submitting these to their audience for evaluation. Sir Alfred Baring Garrod's pioneering work on the discovery of uric acid in the blood of patients suffering from gout was, for example, first presented in a paper read before the Royal Medical and Chirurgical Society in 1848.³¹ This was later published as a *Treatise on Gout and Rheumatic Gout* in 1859 and a third edition was produced in 1876. Garrod's treatise, which was translated into French and German, established his European reputation as a leading expert in the pathology of gout.³²

When a paper challenged accepted medical opinion, it could lead to a heated discussion: John William's paper on painful menstruation, entitled "On the natural history of dysmenorrhoea", provoked a lively debate in which "men of much reputation, such as [Robert] Barnes, Graily Hewitt, [Henry] Gervis [Treasurer of the Obstetrics Society] and [Alfred Lewis] Galabin [Editor of the *Obstetrical Journal*]" participated.³³ William MacCormac's paper on the application of Listerism in military surgery was also challenged.³⁴ The paper was presented to the Metropolitan Counties Branch of the BMA in 1879 and caused a "spirited debate". MacCormac's discussion on the subject was attended by Professor (later Lord) Lister, may

³¹ Dr C J B Williams read the paper before the society in 1848. Anon, 'Sir Alfred Baring Garrod, *Lancet*, Jan. 4, 1908, p. 65.

³² Anon, 'Garrod', pp. 58-59 and *BMJ*, Jan 11, 1908, p. 121.

³³ Anon, 'Sir John Williams', *BMJ*, May 29, 1926, pp. 922-23

³⁴ Based on Joseph Lister's method of using of carbolic acid as an antiseptic during surgery.

well have been, commented his obituarist, “among the most useful debates that has ever taken place in the history of surgery” because Listerism was still in its early stages in Britain and not universally accepted, particularly by the old school of surgeons.³⁵

Sir Richard Quain’s original research into heart disease was also presented to the Royal Medical and Chirurgical Society in 1850. Quain’s paper, which included 83 cases of blockage of the coronary arteries, was considered by the fellows to be ground breaking and was:

listened to throughout with the greatest attention; at its close the fellows, who formed a very large meeting, expressed their opinion of its merits by the unusual compliment of warm applause. Many felt that the meeting might have been prolonged with advantage, so as to have afforded the opportunity for discussing this new and important subject.³⁶

Thus, presenting a paper at one of the medical societies was an essential process in the dissemination of one’s clinical findings to other members of the medical profession.

During the Victorian period, self-experimentation also played a role in scientific research for some medical men.³⁷ The neurologist Henry Head had the nerves in his left arm cut and subsequently stitched them back so he could observe the sensory changes and regeneration of his nervous system. The results of his self-experimentation were published in 1908 in the leading neurological journal of the day, *Brain*, which he edited, thus

³⁵ Anon, ‘Sir William MacCormac’, *Lancet*, Dec. 7, 1901, p. 1618. For a discussion on antiseptic surgery, see W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge, 1995), pp. 132-137.

³⁶ Anon, *Lancet*, Mar. 23, 1850, pp. 367-68, quoted in Penelope Hunting, *The History of the Royal Society of Medicine*, (London, 2002), p. 103.

³⁷ Hugh Morrision Davies who later became a thoracic surgeon (which involved surgery to the chest) and Wilfred Trotter studied “the effects of the nerve section on themselves” by cutting various nerves in their arms. Anon, ‘H. Morrision Davies’, *BMJ*, Feb. 27, 1965, p. 593.

establishing Head's reputation.³⁸ He later became the journal's editor, a position he held from 1910 to 1925.³⁹ George Harley's scientific research and clinical observations were also published in the medical press; they included surviving for three days (and later for fourteen days) on a diet of asparagus in order to "stimulate diabetes".⁴⁰ On another occasion, he swallowed pure nitro-glycerine that caused him temporary paralysis.

Harley Street Editors

Permanent salaried positions on the editorial board of journals such as the *Lancet*, the *BMJ* or the *Medical Press and Circular*, were unusual during this time. The Harley Street practitioners who edited journals largely did so on a part-time basis. Though Bynum and Wilson found that editorship usually occurred early in a medical practitioner's career with a four-to-ten year term as the norm, the Harley Street medical practitioners did not always fit this profile. For some, editorship occurred when they were establishing their career during their late twenties or early thirties: Leonard A. Bidwell was typical of this type.⁴¹ Bidwell, who was a surgeon to the West London Hospital and a member of the West London Medico-Chiurgical Society, was 26 in 1891 when he edited the society's proceedings. When they were superseded by the publication of the *Journal*

³⁸ Hunting, *RSM*, p. 265. The experiment was later reprinted in *Studies of Neurology*.

³⁹ Anon, 'Sir Henry Head', *BMJ*, Oct. 19, 1940, p. 540.

⁴⁰ Reginald Pound, *Harley Street*. (London, 1967), pp. 17-18 and Anon, 'George Harley', *BMJ*, Oct. 31, 1896, p. 1354.

⁴¹ Others included Angel Money, aged 27, Richard Wolfenden, aged 33 and Norman Maclehose, aged 32.

of the *West London Medico-Chirurgical Society*, Bidwell became its editorial secretary.⁴²

The majority of the Harley Street editors were, however, over 40 years of age when they assumed their positions.⁴³ It was also found that the period of employment of the group who were on the staff of medical journals ranged from three to 30 years with the norm being over 10 years. One reason that the group deviated from the Bynum/Wilson model may be that most of them established or edited *specialist* journals and editorship came after they had built a reputation as experts in a particular speciality. Whilst members of the group edited a range of different medical journals, three of the principal journals for the period, the *BMJ*, the *Lancet* and the *Medical Press and Circular*, will be discussed in more detail to assess the cohort's prominence in these publications.

Harley Street and the *British Medical Journal*

In 1853, the *Provincial and Surgical Journal*, founded in 1840, and the *London Journal of Medicine*, established in 1853, merged to form a new journal entitled the *Association Medical Journal*, which became the mouthpiece of the Provincial and Surgical Association.⁴⁴ This was the forerunner of *British Medical Journal*, renamed in 1857 following the formation of the British Medical Association.⁴⁵

⁴² Anon, 'Leonard A. Bidwell', *BMJ*, Sept. 14, 1912, pp. 667-67.

⁴³ This group included Leonard Williams, aged 54, Malcolm Morris, aged 46, Morell Mackenzie, aged 50 and Henry Rayner, aged 53.

⁴⁴ Bartrip, *Mirror of Medicine*, p. 13.

⁴⁵ Christopher C. Booth, *Doctors in Science and Society: Essays of a Clinical Scientist*, (Cambridge, *BMJ*, 1987), pp. 211-12.

For nearly seven decades, from 1860 to 1928, Harley Street medical practitioners dominated the editorship of the *BMJ*. The connection between the *Journal* and Harley Street began with William Orlando Markham, who was editor from 1861 until 1866 when he resigned to become a poor-law inspector. He was replaced by the *BMJ*'s most progressive nineteenth century editor, Ernest Abraham Hart who held the position for three decades until his death in January 1898 when Dawson Williams was appointed.⁴⁶ Williams had contributed to the *Journal* from 1881 and became a member of the editorial staff in 1886. Following his appointment as editor in 1898, he retained this position until January 1928, a month before his death, aged 74.⁴⁷

Markham graduated MD from the University of Edinburgh in 1840 and continued his medical education at Paris and Heidelberg. He trained at Charing Cross Hospital and later accrued additional professional experience at the York Road Lying-in-Hospital and the Western General Dispensary, New Road. When St Mary's Hospital at Paddington opened in 1851, Markham was appointed physician to out-patients. Three years later, he held the position of lecturer in pathology and from 1857, he also lectured in physiology.⁴⁸ Markham, a Gulstonian lecturer at the RCP in 1865, was regarded as a "fluent speaker and a trenchant writer on occasion, especially when he wished to unmask anything like quackery or humbug in the

⁴⁶ Bartrip, *Mirror of Medicine*, *op cit.*, (29), p. 63. In 1869, Jonathan Hutchinson replaced Hart as editor. Hart resumed the role a year later in 1870.

⁴⁷ Peter Bartrip, 'The *BMJ*: a *Retrospect*' in Bynum and Wilson, *Medical Journals*, pp. 140-41.

⁴⁸ Anon, 'William Orlando Markham', *BMJ*, Feb 7 1891, p. 323.

profession".⁴⁹ His acerbic language was not confined to quackery, but extended to specialism and true to type, Markham became an outspoken critic in the *BMJ* of specialists in medicine.⁵⁰

Prior to Markham's appointment as editor of the *BMJ*, the members of the BMA who saw the bulk of their subscriptions go into keeping the *Journal* afloat thought that it represented poor value for money.⁵¹ This tension between the association and the *Journal* had forced Markham's predecessor, Andrew Wynter, to resign. With the arrival of Markham, an unspoken truce was made between the two organisations, as the members of the BMA gradually began to see the *BMJ's* usefulness and acknowledged the high standard of its articles. Despite an increase in the expense of running the *Journal* for the BMA during Markham's tenure, the members remained supportive and the number of new members began to rise. Markham's period of office marked the beginning of mutual respect between the *Journal* and the association, as Bartrip remarked, "never again was the *BMJ's* existence seriously questioned".⁵²

Markham's successor, Ernest Abraham Hart, was the son of a Sloane Street dentist. He pursued his studies at the City of London School where his academic achievements were noteworthy. One of his obituarists reiterated the possibly apocryphal story that "the number of prizes obtained by young Hart was so great that he had to charter a cab to remove them

⁴⁹ Anon, 'Markham', p. 324.

⁵⁰ For a discussion of Markham's views of specialism see, E. A. Heaman, *St Mary's, the History of a London Teaching Hospital*, (London, 2003), pp. 43 and 62.

⁵¹ Bartrip, 'The *BMJ*: a Retrospect', p. 42.

⁵² Bartrip, *Mirror of Medicine*, p. 35.

after each distribution”.⁵³ Academic success achieved at school was sustained during his medical education at St. George’s Hospital where it was said that he was awarded “210 prizes” during his training there.⁵⁴ He proceeded to MRCS in 1856 and then to private practice in the City. This too was an unqualified success: during his first five years his earnings allegedly averaged £2,000 per annum — at a time when the earnings of a successful London physician ranged from between £800 to £3,000.⁵⁵ A growing interest in ophthalmic surgery encouraged him to accept the position of ophthalmic surgeon to St Mary’s in 1863.

Following his appointment to St Mary’s, Hart established a practice in Wimpole Street, which his obituarist remarked “was then by no means the medical Valhalla that it is to-day”.⁵⁶ However, in his eulogy of Hart, the author stated erroneously that, “Mr. Hart was for a short time the only doctor in the street”.⁵⁷ In 1864, there were, in fact, an additional 17 medical practitioners registered in Wimpole Street, including a number of distinguished men such as Charles West and Henry Thompson. In 1871, Hart established his practice in Harley Street and in the same year joined the staff of the Middlesex Hospital under the esteemed recommendation of William Jenner, who did “not think any testimony from me can give weight to one so highly distinguished in the profession as you are ... I hold you to be

⁵³ Anon, ‘Ernest Hart: an Appreciation’ *Jewish Chronicle*, January 14, 1898, p. 11.

⁵⁴ *Ibid.*

⁵⁵ Although, as Digby notes this was not for a “top” physician. This figure above was for the year 1857. H.B. Thompson, *Choice of Profession*, (1857), p. 169, quoted in Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, (Cambridge, 1994), p. 192.

⁵⁶ Anon, ‘Ernest Hart: an Appreciation’, p. 11.

⁵⁷ *Ibid.*

qualified to the highest degree for the post of assistant surgeon to the Middlesex Hospital".⁵⁸ Hart remained in Harley Street until 1873 when he moved to Queen Anne Street.

Hart gained his editorial experience at the *Lancet*, where he was sub-editor to James Goodchild Wakley (d. 1886): Hart's departure to the *BMJ* to take up the position of editor in 1866, "sparked [the] '30 years' war between the two journals."⁵⁹ Bynum who has referred to Hart's "crusading activities" also argued that Hart was "the greatest Victorian editor of the *British Medical Journal*".⁶⁰ In 1910, Hart was described by Sir Henry Trentham Butlin, a Harley Street medical practitioner and President of the BMA, as "a little sallow-faced Jew, with clean-cut features and piercing eyes, active in mind and body and as keen as men are made". Hart poured his energy into the *Journal*. At the start of his editorship, the BMA had approximately 2,000 members who subscribed to the *Journal*, by the time of his death in 1898, as a testimony to his influence, this had increased to 17,000 members.⁶¹ During his tenure, Hart claimed that the superior quality of his *Journal* was directly responsible for the increase in BMA membership. Indeed, the circulation of the *Journal* was almost double that of the membership of the BMA in 1871.⁶² Such was Hart's prominence that he became known nationally as the "voice of the B.M.A.". Moreover, many of the causes that he believed, in such as sanitation, cholera and vaccination

⁵⁸ Ernest Hart, letters received 1841-96, Wellcome, Archives and Manuscripts, ref 5423/1.

⁵⁹ Peter Kandela, "175 years at *Lancet*", *Lancet*, Oct. 23, 1998, p. 1141

⁶⁰ Bynum et al, 'Introduction', in *Medical Journals*, p. 4.

⁶¹ Vaughan, *Doctors' Commons*, p. 131.

⁶² The BMA had 4,403 members and the circulation of the *BMJ* was 7,000. See Vaughan, *Doctors' Commons*, pp. 131-132.

were championed in the pages of the *Journal*. As editor of the *BMJ* he also commissioned contributions from many distinguished medical practitioners, including Sir Joseph Lister, Sir Patrick Manson and Lawson Tait, thereby enhancing the *Journal's* national and international profile.⁶³

When Dawson Williams succeeded to the editorship of the *BMJ*, it was the culmination of years of working his way through the ranks of the *Journal*.⁶⁴ His connection with the *BMJ* began with the writing of reports of clinical lectures at hospitals and on the proceedings of medical societies, in order to supplement his earnings during the early years of consultancy practice.⁶⁵ He was born in 1854, the son of a clergyman and part-time scholar at St. John's College Cambridge. He was expected to follow his father into the church, but decided against it in favour of a career in medicine. Dawson graduated MB/BS (1879) and MD (1881) from the University of London and was awarded a gold medal following both examinations. He became FRCP in 1895 and when he established himself in Harley Street a year later; he was an assistant editor of the *BMJ*, and in 1898 he became the editor. In 1902, the council of the BMA insisted that Williams relinquish his hospital appointment at the Children's Hospital in Shadwell because he was to be employed as the *Journal's* first full-time editor.⁶⁶

⁶³ Vaughan, *Doctors' Commons*, pp. 134 and 136-137.

⁶⁴ He began as contributor to the *Journal* in 1881 and in 1884 he was appointed hospital reporter, then principal sub-editor in 1886 and assistant editor in 1895. See Bartrip, *Mirror of Medicine*, p. 181.

⁶⁵ Scott Stevenson, *Harley Street Mirror*, p. 6.

⁶⁶ *Ibid.*, and Bartrip, *Mirror of Medicine*, p. 181.

When he took up this position, Williams expanded the *Journal* by introducing the weekly *Supplement*, which covered medico-political issues and other matters relating to the Association. According to his Harley Street neighbour and Chairman of the Representative Body of the BMA and Acting Chairman of the Council, Charles Oliver Hawthorne, the *Journal* was for Williams, “post-graduation training brought to the practitioner’s door”.⁶⁷ Williams worked hard for the reform of medical education and the creation of post-graduate medical schools. His period in office coincided with turbulent times both inside and outside the medical profession, which included the introduction of the 1911 Insurance Bill and the onset of the First World War. During the War “he gave unflinching and effective support to the Naval, Army and Indian Medical services, and forwarded with all means at his command their best interests in war”. In recognition of his efforts for the RAMC, he was made CBE in 1919 and received a knighthood in 1921.

By the end of the War, Williams’s health began to suffer, which meant that his final ten years of his editorship were not as illustrious as the first two decades. Nevertheless, part of his lasting legacy was the increase in the circulation and revenue of the *Journal*, and its ability to influence medical opinion through the acceptance of scientific or medical papers from distinguished men such as Sir John Bland-Sutton, President of the Royal College of Surgeons, Sir George Newman, CMO to the Ministry of Health, Sir Patrick Manson the pioneer of tropical medicine, and the distinguished

⁶⁷ Dr. C. O. Hawthorne, ‘Sir Dawson Williams’, *BMJ*, March 10, 1928, p. 422.

bacteriologist, Sir Almroth Wright. These qualities established the *BMJ* during the Edwardian period as “probably at the peak of its standing as a scientific journal”.⁶⁸

Harley Street and the *Lancet*

Up to the mid-nineteenth century, the *Lancet* was the yardstick by which other medical journals could be judged. Despite its irascible editor, Thomas Wakley (1795-1862), and his habit of criticising certain sections of the medical profession and its institutions, the standard of articles on medicine and medical science was high.⁶⁹ Unfortunately, although Harley Street practitioners contributed to the *Journal* and a few undertook editorial work, it is difficult to determine the full extent of their involvement. Historiographical accounts on the *Lancet* mainly concentrate on the life and times of its founder, Thomas Wakley and historians have not investigated the journal's editorial staff in any detail. The problem for the researcher relates to source material, because much of the *Lancet's* archive for the period up to the First World War has not survived and their extant archives only contain records of writers of anonymous articles from 1926.⁷⁰

James Goodchild Wakley succeeded his father Thomas as editor in 1862. Although he qualified in medicine, he never practised and “made no pretension to a thorough knowledge of medicine or science.” He frequently sought the advice of the Harley Street surgeon, Sir John Tweedy. Wakley

⁶⁸ Bartrip, ‘*The BMJ*’, pp. 140- 141.

⁶⁹ Jean Loudon and Irvine Loudon ‘Medicine, Politics and the Medical Periodical 1800-50, in Bynum et al, *Medical Journals*, p. 62.

⁷⁰ A. M. Cooke in *The History of the Royal College of Physicians of London*, Vol. 111, (Oxford, 1972), p. 1135. The most comprehensive history of the *Lancet* and its founder was by Squire Sprigge, *The Life and Times of Thomas Wakley*, (London, 1899).

remarked in a paper published posthumously in 1886, that he had been, “materially aided by Mr. John Tweedy, Dr. J. A. Marston, and Dr. J. G. Glover ... [and had] great reliance in the soundness and fairness of their judgement, their scientific and literary ability, and the integrity of their character”.⁷¹ Even though Tweedy wrote only a few clinical papers and no textbook, this seemed no impediment to his election to a permanent post on the staff of the *Lancet* — presumably, his earlier anonymous contributions to the journal secured his position. Tweedy was later offered the editorship of the journal, but he was forced to decline on the grounds of his professional commitments.

Others from Harley Street editorially associated with the *Lancet* included William Henry Battle, consulting surgeon to St Thomas’s Hospital who was on the staff for more than 20 years and who contributed articles on surgical subjects. He succeeded Sir John Tweedy as general surgical adviser and was involved with editing the section of the journal entitled ‘A Mirror of Surgical Practice’.⁷² Arthur H. N. Lewers obstetric physician to the London Hospital was a regular contributor to the *Lancet* and was on its staff for 15 years.⁷³ He was also a regular editorial contributor to the *Proceedings of the Obstetrical Society* and *The Medical Society of London*. Lewers’s textbook on diseases of women ran to seven editions and remained popular with medical students for some 20 years.⁷⁴ Tilbury Fox, whose medical career concentrated on the “study of dermatology as a speciality”, was for many

⁷¹ Quoted in Anon, ‘Sir John Tweedy’, *BMJ*, Jan 12, 1924, pp. 87-88.

⁷² Anon, ‘William Henry Battle’, *Lancet*, Feb. 15, 1936, pp. 396-397.

⁷³ Anon, ‘Arthur H.N. Lewers’, *Lancet*, Feb. 24, 1934, p. 430.

⁷⁴ *Ibid.*

years connected editorially with the *Lancet*.⁷⁵ In 1883, Angel Money, who had written a popular textbook on diseases of children, also joined the journal's staff.⁷⁶ The consultant obstetrician to St George's Hospital, Robert Barnes, made a living by writing on medical matters during the early days of his medical career, and was for a long time on the staff of the *Lancet*.⁷⁷ Willmott Henderson Evans, later consulting surgeon to the Royal Free, was also on the staff "over a long period".⁷⁸

The ophthalmic surgeon to St George's Hospital, Robert Blundell Carter first joined the editorial staff of the *Lancet* in 1868 and contributed a weekly leading article to the journal. He was allegedly the first member of the *Lancet* editorial staff to use a typewriter and was renowned for "wearing two pairs of spectacles".⁷⁹ From the late 1870s, his work as a member of the GMC occupied much of his time and his connection with the journal waned. On his retirement from the Council in 1899, he resumed his writing although he contributed less frequently to the *Lancet*.

The Medical Press and Circular

In 1865 the *Dublin Medical Press*, (1839) and the *London Medical Circular* (1852) merged to form the weekly *Dublin Medical Press and Circular*.⁸⁰ Two years later in 1867, "Dublin" was removed from its title, even though the *Journal* continued to comment on Irish medical matters through its "Irish

⁷⁵ Anon, 'Tilbury Fox', *BMJ*, June 14, 1879, pp. 915-116.

⁷⁶ Anon, 'Angel Money', *Lancet*, Oct. 29, 1904, p. 1256.

⁷⁷ Anon, 'Robert Barnes', *Lancet*, May 25, 1907, p. 1465.

⁷⁸ Anon, 'Willmott H. Evans', *Lancet*, Sept, 17, 1938, p. 701.

⁷⁹ Penelope Hunting, *A History of the Society of Apothecaries*, (London, 1998), p. 289.

⁸⁰ Robert J. Rowlette, *The Medical Press and Circular 1839-1939, a Hundred Years in the Life of a Medical Journal*, (London, 1939), pp. 65-66.

supplement" which largely reflected the views of the Irish Medical Association.⁸¹

In common with the *BMJ* and the *Lancet*, Harley Street men were prominent members of staff on *The Medical Press and Circular* and they exerted their influence at various times between 1861 and 1918. Arthur Threhorn Norton, surgeon to St. Mary's Hospital had a share in the *Medical Press and Circular* and was the journal's first English Editor. Though the exact date of his involvement is unknown, it is believed to date from the merger and records show that he served as editor for the journal for some 30 years, until about 1891 and continued his proprietary interest until his death in 1912.⁸² During this period, Norton contributed a large number of articles on surgical subjects in addition to giving the *Circular* "a faithful record of the many dramatic advances in medical science which passed before his eyes".⁸³ From the 1870s, the tone of the *Circular* and its subject matter was restrained; "the acerbity of the two parent journals had largely disappeared".⁸⁴ On a few occasions, however, the *Circular* adopted a liberal stance, such as on the admission of women into medicine. Its editor, Norton, was "an ardent supporter of the movement for admitting women to medical degrees."⁸⁵ The *Circular* championed the right of women to enter medicine on the grounds of liberty and justice and Norton later became one of the founders of the London School of Medicine for Women, when it was

⁸¹ Rowlette, *Medical Press*, p. 88.

⁸² *Ibid.*, pp. 104-05.

⁸³ *Ibid.*, p. 105.

⁸⁴ *Ibid.*, pp. 89-90.

⁸⁵ Anon, 'Arthur Threhern Norton', *Lancet*, Aug. 17, 1912, p. 491.

established in 1874. Other controversial perspectives taken by the *Circular* in the 1880s, encompassed the abolition of the death penalty or its use only for severe crimes. Norton was periodically aided by other Harley Street men, such as Leonard Llewelyn Bulkeley who was editor of the *Circular* from 1874 to 1882.

The Harley Street physician David Walsh was editor of *Medical Press and Circular* from 1903 to 1915. Walsh graduated MS/MD from Edinburgh University in 1896 and later became Lister's dresser at the Edinburgh Royal Infirmary. Following the discovery of the radioactive elements of polonium and radium by Pierre and Marie Curie in 1898, a huge interest in X-Rays and radiology developed in Britain. A pioneer of the X-Ray, Walsh arranged a meeting of scientists and medical men at his office at the *Medical Press and Circular* to establish a society to promote their interests, and in 1897 the Röntgen Society was born with Walsh as Honorary Secretary. Walsh is credited as having introduced the readers of the *Circular* to X-Rays and in 1897, he published *The Röntgen Ray in Medical Work*, "the first book in the world on the subject".⁸⁶

In addition to his editorials on X-Ray and radiology, Walsh contributed articles on quackery and diseases of the skin. During his tenure as Editor, the *Circular* was active in promoting research in the interest of scientific advancement, particularly during the anti-vivisection debates where the *Circular* received several articles in support of the need for

⁸⁶ Rowlette, *Medical Press*, p. 109.

experimentation in science and medicine from Sir Victor Horsley.⁸⁷ From 1906 to 1909, Walsh received considerable help from Harley Street's Hubert Elwyn Jones Biss, physician to Mr. Gladstone.

Leonard Williams, physician to the Metropolitan Hospital who had a particular interest in dietetics and spa treatments, succeeded Walsh as the editor of the *Medical Press and Circular* (1915-1918). His association with the *Circular* continued for many years. He contributed a weekly article "on general topics" using the pseudonym "Sinapis".⁸⁸ Williams was a dogmatic character who raged against "over-eating ... over-drinking, over-clothing, tight neck-wear, high heels, central heating, tobacco, cane sugar, and the cult of athleticism in girls schools".⁸⁹ Several Harley Street men contributed to the *Circular*, including such respected members of the medical profession as Professor Henry MacNaughton-Jones.

Other Medical Journals

There was a wide range of other medical publications, which the cohort established or edited many of which reflected their diverse experience and knowledge, some of these are listed below:

1. The distinguished scientist and surgeon, George Busk, an authority on craniometry, palaeontology and marine zoology, was the editor of: *Microscopic Journal*, *Quarterly Journal of Microscopic Science*, *Natural History Review* and *Journal of Ethnological Society*.

⁸⁷ *Ibid.*, pp. 110-111.

⁸⁸ Anon, 'Leonard Williams', *BMJ*, Aug. 26, 1939, p. 472.

⁸⁹ *Ibid.*

2. Theo. N. Kelynack, consulting physician to Mount Vernon Hospital was editor of *British Journal of Tuberculosis*, (1907-1934), the *British Journal of Inebriety* from 1903 and of *The Child*, (1910-1927).⁹⁰

3. Walter Goldie Howarth, who has been the longest serving editor to date of the *Journal of Laryngology and Otology*, held the position for 31 years from 1929 to 1960.

4. Richard Lake was the sub-editor of *Journal of Laryngology* from 1897 –1898, and joint editor from 1899-1902.

5. Norman Macmillan Macle hose was an editor of *Ophthalmic Review* from 1891-1899, before he arrived in Harley Street in 1904.

6. Charles Devereux Marshall, staff surgeon, Royal Navy was sub-editor of the *Ophthalmoscope*.⁹¹

7. Leslie J. Paton, later consulting ophthalmic surgeon to St. Mary's Hospital, was the chairman and managing director of the *British Journal of Ophthalmology*.⁹² Walter Hamilton Hylton Jessop was also Managing Director of this *Journal* from 1916, until his death six months later.⁹³

8. Henry Rayner, a specialist in psychological medicine and physician for mental diseases at St Thomas's Hospital was co-editor of the *Journal of*

⁹⁰ *Who Was Who, 1941-1950: A Companion to Who's Who, Containing the Biographies of those who Died During the Decade 1941-1950*, Vol. 4, (London, 1980), p. 739.

⁹¹ Anon, 'Charles Devereux Marshall', *Lancet*, Oct. 12, 1918, p. 502.

⁹² Anon, 'Leslie J. Paton', *BMJ*, June 12, 1943, p. 741.

⁹³ Anon, 'Walter Hamilton Hylton Jessop', F.W. Andrews, W. McAdam Eccles, G.E. Gask, W.D. Harmer, H. Thursfield, and H. Williamson eds., *Saint Bartholomew's Hospital Reports* (London, 1920) Vol. Liii, 1917 and 1918, p. 2.

Mental Science from 1895 to 1911 and President of the Medico-Psychological Society.⁹⁴

9. John Mitchell Bruce was on the staff of the *Medical Times and Gazette* and later co-editor of the *Practitioner* from 1919-1921.

10. Edmund Alexander Parkes was the editor of the quarterly *British and Foreign Medico-Chirurgical Review* from 1852; however, his editorship terminated in 1855 when the Government sent him to Renkioi, Turkey during the Crimean War to establish a new hospital.⁹⁵ The review ceased publication in 1877.⁹⁶

Other men such as Alfred Ernest Jones and James Harry Sequeira founded or edited journals after they left Harley Street.⁹⁷

Hospital Reports and Hospital Journals

Publications were one route for medical practitioners to establish themselves and gain visibility within the profession. Those who worked in special hospitals could further develop their own area of expertise by writing textbooks and articles on their special interest or specialism, which was, according to Lindsay Granshaw, an effective means to becoming leaders in their domain.⁹⁸ Moreover, it enabled these medical men to define their

⁹⁴ Anon, 'Henry Rayner', *BMJ*, Feb. 20, 1926, p. 351.

⁹⁵ *Munk's*, 1854, pp. 76-77.

⁹⁶ Anon, 'Professor Parkes', *Lancet*, Mar. 25, 1876, p. 481.

⁹⁷ Jones who founded the British Psycho-Analytical Society in 1919 also established the *International Journal of Psycho-Analysis* in 1920. For further details, see *The Medical Who's Who*, 1925, p. 337. J.H. Sequeira became the editor of the *British Journal of Dermatology*, Anon, 'J. H. Sequeira', *BMJ*, Dec. 11, 1948, p.1040.

⁹⁸ Lindsay Granshaw discusses the role of publications in special hospitals in greater detail in "Fame and Fortune by means of Bricks and Mortar": the Medical Profession and

emerging medical fields. Taking up editorial posts for various London hospital publications may also be seen as another way to establish a reputation, when efforts to secure posts in hospitals were so competitive. Unable to advertise directly, publications, especially in the capacity of an editor, may have provided the cohort with increased visibility in the medical profession.

At least 18 per cent ($n = 118$) of the cohort contributed to hospital reports and some such as Nester Tirard (later Sir) and Professor John Phillips (later Sir) were on the editorial staff. In 1893, Phillips published his *Outline of Diseases of Women* and was made co-editor and treasurer of the *King's College Hospital Reports* — a position he held until 1901. Tirard who was for some time editor of the *King's College Hospital Reports*, later became emeritus professor of medicine at King's College and consulting physician to King's College Hospital. Tirard made his name with the revision of the *British Pharmacopeia*, a treatise on drugs and their preparation, for the 1898 and 1914 editions; subsequently, he was appointed senior editor in 1914. Tirard also held the role of secretary to the Pharmacopeia Committee of the General Medical Council from 1895 to 1915.⁹⁹

Greville Matheson Macdonald, Tirard's close friend from his student days at King's College Hospital, founded the *King's College Magazine*. Like Tirard, Macdonald was a professor at King's College and consulting

Hospitals in Britain, 1800-1948" in Lindsay Granshaw and Roy Porter, *The Hospitals in History*, (London, 1989), pp. 199-200.

⁹⁹ Anon, 'Sir Nestor Tirard', *BMJ*, Nov. 17, 1928, p. 917.

physician to King's College Hospital. As a student, Macdonald acted as one of Lord Lister's clerks, but later developed a speciality in laryngology, which led to a large and successful practice in Harley Street. He owed his first appointment in his chosen field to Sir Morell Mackenzie, who proposed him for the position of house surgeon at the Hospital for Diseases of the Throat, Golden Square in 1886. Whilst Mackenzie was overseas attending the Emperor Frederick at San Remo and Charlottenburg, Macdonald ran his private practice in Harley Street for him.¹⁰⁰ Macdonald had been brought up in a literary environment, as his father George was a poet and novelist. In addition to writing on medical matters, Macdonald published several philosophical essays and studies of human personality.¹⁰¹

William Church was editor of the *St. Bartholomew's Hospital Reports* from 1877 to 1893.¹⁰² As he was a general physician with no special interest, his contributions to the reports covered a wide spectrum of medical topics, which ranged from the effects of cholera to an analysis of 700 cases of rheumatic fever.¹⁰³ Not all the editors had such a long tenure as Church, for several including Harold Pritchard who edited the *St. Bartholomew's Hospital Journal* for a couple of years, increasing demands of hospital and private practice forced them to relinquish their editorial work.¹⁰⁴ Several of the cohort did editorial work during their student days. While he was a student at UCH Otto May, a specialist in neurology, was one of the founder

¹⁰⁰ Anon, 'Greville Macdonald, M.D.', *BMJ*, Nov. 18, 1944, pp. 676-77.

¹⁰¹ Anon, 'Greville Matheson Macdonald, *Lancet*, Nov. 25, 1944, p. 708.

¹⁰² Anon, 'Sir William Church, BT', *BMJ*, May 5, 1928, p. 778.

¹⁰³ *Ibid.*, p. 780.

¹⁰⁴ Anon, 'Harold Pritchard', *BMJ*, Dec. 10, 1938, p. 1233.

members of the *University College Hospital Magazine* and became its first editor.¹⁰⁵

Publications by Harley Street Men

If the sheer number of Victorian medical periodicals is, according to Jeanne Peterson, “nearly overwhelming” then the task of researching the range and number of publications by Harley Street men is equally arduous.¹⁰⁶ To take one of the most prodigious examples: when Frederick Parkes Weber, “the greatest authority in his lifetime on rare disease”, celebrated his 80th birthday in 1943, his friends presented him with a number of articles, which he had published in various journals.¹⁰⁷ This collection when amassed into seven volumes, amounted to almost 1,000 separate publications. Yet this was not even Weber’s total output, as he continued to have articles printed in the *BMJ*, “long after he had reached the age of 90”.¹⁰⁸ Weber, though prolific, was not an isolated example: a whole book is devoted to a bibliography of the published papers of Sir James Mackenzie.¹⁰⁹ Although they are not unique examples from the cohort, they are, nevertheless, exceptional cases.

Other Harley Street men who were amongst the most prolific writers include Humphry Davy Rolleston, Edward Charles Ryall and the physician

¹⁰⁵ G. H. Brown, *Lives of the Fellows*, (London, 1955), Vol V, p. 274.

¹⁰⁶ Peterson, ‘Medicine’, p. 29.

¹⁰⁷ Weber’s name is associated with four diseases, including Rendu-Osler-Weber disease, Weber’s disease, Weber-Dimitri disease. Brown, *Fellows*, p. 438

¹⁰⁸ Anon, ‘F. Parkes Weber’, *BMJ*, June 9, 1962, p. 1630.

¹⁰⁹ For details of these diseases see, Anon, ‘F. Parkes Weber’ *BMJ* June 9, 1962, p. 1630 and Anon, ‘Sir James Mackenzie’, *BMJ*, Jan. 31, 1925, p. 242.

and anti-evolutionist Charles Elam.¹¹⁰ Many of the cohort were described as “frequent writer[s] of articles”, including Bryan Donkin who wrote a large number of articles on criminology, mental disease and venereal disease for the medical press and the *Times*.¹¹¹

Retirement from public or hospital appointments did not necessarily result in the cessation of writing; there were many individuals from the group who continued to contribute articles to the medical press well past their retirement age. In 1954 David Nunes Nabarro, who was then 80 years old and had been consulting pathologist to Great Ormond Street Hospital, produced one of his most significant works, *Congenital Syphilis*, which was considered by many in the medical profession to be a classic.¹¹² Edward David Darlean Davis, an ENT specialist, continued to contribute articles to learned journals into his 70s and attended meetings at medical societies into his 90s.¹¹³

In contrast, there was a minority of medical practitioners such as Henry Thompson, physician to Middlesex Hospital, who were not prolific. This was not because their publications were of little value, rather Thompson's clinical lectures, which were published on his retirement from

¹¹⁰ Ryall was a prolific writer whose work included an atlas of 'Operative Cystoscopy' containing 670 illustrations. Anon 'Edward Canny Ryall', *Lancet*, Feb. 24, 1934, p. 431. *Elam's* writing was described as 'voluminous' he vociferously denounced the theory of evolution and in particular he challenged the teachings of Darwin, Huxley, Spencer and Tyndall. Anon, 'Charles Elam', *BMJ*, 20 July, 1889, p. 161. There were a number of other such as Julius Althaus was also referred to as a voluminous writers see Anon, 'Julius Althaus', *BMJ*, June 16, 1900, p. 1508.

¹¹¹ Anon, 'Sir Bryan Donkin', *BMJ*, Aug. 6, 1927, p. 240.

¹¹² Nabarro had left Harley Street in 1938; he had been there since 1914. Anon, 'D.N. Nabarro', *BMJ*, Oct. 11, 1958, p. 919.

¹¹³ Anon, 'E. D. D. Davis', *BMJ*, 27 March, 1976, p. 776.

the Middlesex Hospital were described as "an extremely able and valuable production".¹¹⁴ James Andrew and Sir Charles Ryall also published few medical articles.¹¹⁵ Although Andrew did not publish many books, his Lumleian lectures of 1884 and his Harveian Oration of 1890 at the RCP were published in the medical press. Ryall who was senior surgeon to the St Mark's Hospital for Cancer, Fistula and other diseases of the Rectum, had an active professional and social life that claimed most of his attention. Nevertheless, "what he did write" according to his obituarist, "stood the test of time".¹¹⁶ It was clear that among those who wrote little, many valued substance over quality. Samuel Jones Gee, physician to St. Bartholomew's Hospital exemplifies this type: "Dr. Gee" according to his obituarist, "was not a prolific writer; solidity rather than ephemeral attraction was his aim".¹¹⁷ Gee, made his name by contributing articles to Reynold's *System of Medicine* and like many others, wrote early in his career. An appointment as assistant physician to St. Bartholomew's Hospital followed soon after.¹¹⁸

The view that publication was also a form of publicity in the Victorian and Edwardian period is further supported by the fact that writing was eschewed by some as an unseemly form of self-promotion in the medical market place.¹¹⁹ A small number of the cohort were concerned that their

¹¹⁴ Anon, 'Henry Thompson', *BMJ*, July 31, 1897, p. 320.

¹¹⁵ Andrew "wrote little, but what he wrote was good", Anon, 'James Andrew', *BMJ*, May 8, 1897, p. 1196.

¹¹⁶ Ryall's interests included membership of the Council of the RCS, President of the section of Proctology at the RSM, fishing, golfing and mountaineering. Anon, 'Sir Charles Ryall', *BMJ*, Sept. 16, 1922, p. 534.

¹¹⁷ Anon, 'Samuel Jones Gee', *Lancet*, Aug. 19, 1911, p. 554.

¹¹⁸ Anon, 'Samuel Jones Gee', *BMJ*, Sept. 16, 1911, p. 411.

¹¹⁹ For an example of this, see Anon, Obituary, 'Herbert Sherwell Clogg', *Lancet*, Dec. 31, 1932, p.1460.

writing should be categorised as erudite. Whilst Thomas Colcott Fox, physician for diseases of the skin at Westminster Hospital, contributed a large number of articles to journals on dermatology, his obituarist remarked that Fox was "too conscientious to condescend to the preparation of professional 'pot-boilers'".¹²⁰ Hunter Finlay Tod, senior aural surgeon at the London Hospital, wrote only a modest amount but what he wrote was well received. According to Tod's colleague Lambert Lack, the quality of Tod's contributions was more important than the quantity and his "writings never savoured of advertisement".¹²¹

Recognised authorities in a specialist area tended to publish the results of their work. Contributions by innovative practitioners, such as the surgeon Arthur Edward James Baker, who was one of the country's pioneers in abdominal surgery, were frequently described as "important" and "numerous."¹²² Frederic Samuel Eve, who was prominent as a surgeon-pathologist, contributed at least 60 articles to the *Transactions of the Pathological Society*. Medical practitioners such as Eve did not necessarily confine their writing to specialist journals; Eve also contributed articles to the *Clinical Society's Transactions*, the *Medical Society* and the *JRSM*, which were based on his "wide pathological knowledge". Most of those who had a special interest or who were specialists, published a number of papers or books. There were some exceptions and the ophthalmologist, Sir Anderson Critchett, was part of this minority. He was renowned

¹²⁰ Anon, 'Thomas Colcott Fox', *Lancet*, May, 13, 1916, p. 1017.

¹²¹ Anon, 'Hunter Finlay Tod', *Lancet*, Feb. 3, 1923, p. 257.

¹²² Anon, 'Arthur Edward James Baker', *Lancet*, Apr. 22, 1916, p. 883.

internationally as a "leader amongst eye men of all countries" and a great surgeon, but he was not a prolific writer.¹²³ Though the output of the Harley Street medical practitioners varied, the majority of those who published, that is, 75 % ($n = 418$) published in book form.¹²⁴

These publications were examined to determine their contribution to the advancement of medical knowledge. Most of the eminent medical practitioners in Harley Street, particularly those who were on the staff of specialist hospitals or who specialised in a particular area of medicine or surgery at the teaching hospitals, published the results of their research.¹²⁵ Those who would later become distinguished physicians, such as Bertrand Edward Dawson (later Viscount Dawson of Penn), whose special interest was disorders of the alimentary tract, typically contributed to numerous medical journals, hospital reports and published textbooks or monographs.¹²⁶ Isaac Baker Brown's reputation as a fashionable accoucheur was created by the publication of one of his early works, the *Surgical Diseases of Women* (1854), which, "established his celebrity as an operator

¹²³ Anon, 'Sir Anderson Critchett', *BMJ* Feb. 14, 1925, p. 339.

¹²⁴ This includes articles or contributions to a book such as an edited volume.

¹²⁵ There are many examples, which include Camac Wilkinson who specialised in the treatment of tuberculosis and established a number of clinics before the First World War. His publications included letters, articles and books on consumption and tuberculosis. Anon, 'W. Camac Wilkinson', *BMJ*, March. 2, 1946, p. 335. Phineas Simon Abraham wrote extensively on dermatological subjects particularly leprosy and he edited the journal of the Leprosy Investigation Committee. Anon, 'Phineas Simon Abraham', *BMJ*, March 12, 1921, p. 406. Marmaduke Stephen Mayou wrote widely on ophthalmology and pathology, his Hunterian Lectures on "Inflammation in the Conjunctiva" were also published. Anon, 'Marmaduke Stephen Mayou', *BMJ*, July 28, 1934, p. 185. R. E. Bickerton, made a significant contribution to the literature of his ophthalmology. 'Anon, 'R.E. Bickerton', *BMJ*, Oct 1, 1949, p. 761.

¹²⁶ Anon, 'Viscount Dawson of Penn', *BMJ*, March 17, 1945, p. 389. Dawson contributed a number of articles on a variety of medical subjects, such as Allchin's, *Manual of Medicine*, see G. H. Brown, *Lives of the Fellows*, (London, 1955), Vol. V. 1903, p. 448

at once bold, ingenious, and successful, and of itself will ensure his memory".¹²⁷

Many of the Harley Street group were enthusiastic self-advertisers and Sir Morrell Mackenzie demonstrated how medical practitioners were anxious to promote the results of their research. He wrote to Ernest Hart at the *BMJ*, from his address at 19 Harley Street, in June 1887 to say:

I should be very much obliged if you would allow my work on Hay-fever and paroxysmal sneezing to be noticed in the *British Medical Journal* if possible the week after next. As the Hay-fever portion originally appeared as a lecture in the *BMJ*, it has never really been thoroughly received; it has now as you will see swelled into a volume of some considerable size.¹²⁸

Mackenzie, who had published popular works in his specialist area of laryngology, such as his *Manual of Diseases of the Throat and Nose*, was aware of the value of print in establishing a reputation.¹²⁹

Textbooks and the Publication of Lecture Notes

Harley Street practitioners, particularly those who lectured at one of the teaching hospitals or those who had a specialist subject, wrote handbooks, manuals, textbooks for students and guides for general practitioners.¹³⁰ In general, those who were specialists published the results of their clinical investigations. In addition to published lectures, textbooks and manuals

¹²⁷ Anon, 'Mr. Isaac Baker Brown', *Lancet*, Jan. 25, 1873, p. 151.

¹²⁸ Ernest Hart, letters received 1871-96, Wellcome, Archives and Manuscripts, ref 5424/16.

¹²⁹ Morrell Mackenzie, *A Manual of Diseases of the Throat and Nose: Including the Pharynx, Larynx, Trachea, Oesophagus, Nasal Cavities and Neck*, (London, First published in 1880, 2nd edition 1884).

¹³⁰ The list is extensive and included, Arthur Whitfield who wrote *Handbook of Skin Diseases and their Treatment*. Anon, 'Arthur Whitfield', *BMJ*, Feb. 15, 1947, p. 274, George Ernest Herman's *Student's Handbook of Gynaecology*. Anon, 'George Ernest Herman', *BMJ*, March 21, 1914, p. 690. John Mitchell Bruce's *Materia Medica and Therapeutics*, (1884) which became a popular textbook amongst students. Anon, 'John Mitchell Bruce', *BMJ*, July 13, 1929, p. 77, George Ernest Herman's text book *First Lines of Midwifery* was first published in 1891 and was still popular over twenty years later. Anon, 'George Ernest Herman', *Lancet*, March 21, 1914, p. 857.

were often the result of a record of the case notes within the medical practitioner's practice. Textbooks by skin specialists such as Henry Radcliffe Crocker, were commonly published during this time. Crocker reproduced the results of his case studies in *Atlas of the Diseases of the Skin* (1896) and it became one of the standard reference books at the time. Like many medical textbooks of the period, Crocker's *Atlas* was directed not only to dermatologists, but also to practitioners of general medicine.¹³¹

Producing popular medical textbooks not only enhanced the cohort's reputation and experience, but was also an important display of their medical knowledge. Arthur Lewers, who was "an expert in dealing with cancer of the cervix", wrote a textbook on diseases of women that was popular with students for over 20 years, and went through seven editions. Lewers's recognition amongst the medical profession was due to the direct contact and experience in his medical practice. He was an obstetrician whose services were in demand and who had taken careful case notes from the extensive range of his patients.¹³²

Other classic textbooks included Edmund Alexander Parkes', *Manual of Practical Hygiene* (1864). From 1863, Parkes worked at the Royal Victoria Military Hospital at Netley, Hampshire: this was an impressive structure of 138 wards incorporating 1,000 beds. Netley also offered postgraduate instruction to almost 3,000 students annually who wished to gain clinical experience in hygiene. Parkes developed a reputation as a good teacher and

¹³¹ Anon, 'Henry Radcliffe Crocker', *BMJ*, Sept. 11, 1909, p. 729.

¹³² In 1902, Lewers published his clinical monograph on the cancer of the uterus. Anon, 'Arthur H.N. Lewers', *Lancet*, Feb. 24, 1934, p. 430.

in 1864, he published the first edition of *The Manual of Practical Hygiene*. This was the first textbook on hygiene by an English author and “became the model text-book upon which many other English authors based their own publications”.¹³³ The book was written specifically for students studying various methods of disease prevention in preparation for military or civil posts. It went through four editions in Parkes’ life; an eighth was published in 1891 and the book was subsequently translated into several European languages.

Parkes published several dozen papers and submitted reports to Netley once a year on matters relating to hygiene and in particular to developments in bacteriology. From the groundbreaking work he undertook, Parkes became known as the founder of the science of modern hygiene and was especially acknowledged for his work on military hygiene. Parkes’ book had become so widely used by civilian practitioners that in 1873 he decided to adapt it for Civil Medical Officers of Health and added a new chapter on disinfection.

Not all the textbooks published by the cohort were on specialist topics. Many, such as Alfred Baring Garrod’s *Essentials of Materia Medica and Therapeutics* (1855), derived from teaching experience and catered for the standard requirements of the medical students’ curriculum. Garrod was Professor of Materia Medica and Therapeutics at King’s College Hospital in

¹³³ Dorothy E. Watkins, ‘The English Revolution in Social Medicine: 1889-1911’, (London, 1984), pp. 338 and 359.

1851 and many of his lectures were condensed in this book.¹³⁴ Some, such as William Hale-White owed their fame to the publication of their textbooks; Hale-White's popular *Materia Medica, Pharmacy, Pharmacology and Therapeutics*, (commonly referred to as "Hale-White"), ran to twenty-six editions.¹³⁵ He was active in medical journalism and edited *Guy's Hospital Reports* (1886-193), and was later one of the founders and first editor of the respected British journal, *Quarterly Journal of Medicine* (1907-1929).¹³⁶

Up to the start of the First World War, medical textbooks were typically the work of one author. Frederick William Price recognised the importance of the specialist and acknowledged that the expansion of specialised medical knowledge went beyond the limits of the individual practitioner. Price liaised with practitioners who were authorities in their field to produce a textbook that would reflect modern medicine: their contributions were published in the 1922, *Textbook of the Practice of Medicine*, which was later re-titled *Price's Textbook of Medicine*. Price was a consulting cardiologist and prolific writer on heart disease and other medical conditions; his book was popular and it ran to eight editions.¹³⁷ Price was so proud of his magnum opus that when "one night during the 'blitz' his home in Harley Street was destroyed ... he was found walking in the street in his pyjamas, hugging his first love, the manuscript of a new

¹³⁴ This was deemed by his obituarist as the standard textbook on the subject until the end of the nineteenth century, and it was republished many times Anon, 'Sir Alfred Baring Garrod', *BMJ*, April 4, 1926, p. 58 and Anon, 'Sir Alfred Baring Garrod', *Lancet*, Jan. 4 1908, p. 66.

¹³⁵ Brown, *Fellows*, 1888, p. 329

¹³⁶ J. M. H. Moll, *Presidents of the Royal Society of Medicine*, (London, 1996), pp. 273-74.

¹³⁷ Anon, 'F.W. Price', *BMJ*, March 30, 1957, p. 765 and Brown, *Fellows*, pp. 338-38.

edition of the famous *Textbook of the Practice of Medicine*'.¹³⁸ William Johnson Walsham also achieved eminence because of his textbook *Surgery: its Theory and Practice*, which at the time of his death in 1887 was in its eighth edition.¹³⁹ Samuel Fenwick's *The Student's Guide to Medical Diagnosis*, first published in 1869, went to nine editions, and his *Outlines of Medical Treatment* (first published in 1879), resulted in four editions within a few years.¹⁴⁰ Cuthbert Lockyer, described as one of the leading gynaecologists in London, collaborated with Mr. T. Watts Eden to produce *Gynaecology, a Textbook for Students and Practitioners*.¹⁴¹ He went on to publish the large tome *Fibroids and Allied Tumours*; unfortunately, because his research had taken so long to complete, much of the information was out of date and inaccurate by the time his book was published.¹⁴²

The cohort's career development was also assisted by the translation of recognised international medical texts. Knowledge of a foreign language was a useful tool for a small number of men in their professional advancement.¹⁴³ When Arthur Gamgee was in the early stages of establishing his career, he translated *Hermann's Physiology* in 1875. As

¹³⁸ *Ibid.*

¹³⁹ Anon, 'William Johnson Walsham', *BMJ*, Oct. 10, 1903, p. 945.

¹⁴⁰ Anon, 'Samuel Fenwick', *BMJ*, December 27, 1902, p. 1973.

¹⁴¹ Anon, 'Cuthbert Lockyer', *BMJ*, Sept. 7, 1957, pp. 593-94.

¹⁴² Other textbooks written by the cohort included Edward Reginald Morton, *Essentials of Medical Electricity and Radiology*, (London, 1910), Arthur Whitfield, *A Handbook of Skin Diseases and their Treatment* (London, 1907), Paul Roth's, *Orthopaedics for Practitioners* (London, 1920), Arthur E. J. Barker translated Heinrich Frey's *Histology and Histo - Chemistry of Man* from German. Anon, 'Arthur E.J. Barker', *BMJ*, April, 22, 1916, p. 607.

¹⁴³ Translations were part of their career development for others such as Herbert Morley Fletcher, who translated C. van Kahlden's *Method of Pathological Histology* from the original German in 1894. Anon, 'Herbert Morley Fletcher', *BMJ*, Sept. 16, 1950, p. 683. Henry Hancock translated Velpeau's *Regional Anatomy* and later became known for particular operations on the foot. Anon, 'Henry Hancock', *Lancet*, Jan. 17, 1880, p. 110.

there was "a dearth of textbooks on physiology" in the period, his accurate translation became a standard textbook and was republished in 1878.¹⁴⁴ He later became Professor of physiology at Owens College, Manchester. William Watson Cheyne's translation of Robert Koch's *Investigation into Etiology of Traumatic Infective Diseases* (1880) was an important work, which brought Koch, one the founders of modern bacteriology, to the attention of the English speaking medical practitioners. In the same year, Cheyne won the Jacksonian prize for his dissertation on the history, principles, practice and results of antiseptic surgery, which was eventually published as *Antiseptic Surgery*.¹⁴⁵

Collaboration

Several of the cohort collaborated with other medical practitioners in publishing articles or books.¹⁴⁶ Many of the men who co-authored textbooks, monographs or other medical reference books worked with their fellow Harley Street practitioners.¹⁴⁷ Cheyne published *Tuberculous Disease of Bones and Joints* with Frederic Francois Burghard, a fellow Harley Street surgeon. William Henry Battle a consulting surgeon at St. Thomas's Hospital and author of a number of popular works on acute abdominal conditions joined forces with another Harley Street surgeon, Edred Corner,

¹⁴⁴ Anon, 'Arthur Gamgee', *British Medical Journal*, April 10, 1909, pp. 933-934. Gamgee made his name with his path-breaking *Text-book of the Physiological Chemistry of the Animal Body*, published in 1880. Anon, 'Arthur Gamgee', *Lancet*, Apr. 17, 1909, p. 1142.

¹⁴⁵ Anon, 'Sir William Watson Cheyne', *BMJ*, 30 Aug. 1932, pp. 821-22.

¹⁴⁶ They include D.N. Nabarro who contributed an article with Dr Leonard Hill to the *Lancet*. Anon, 'D. N. Nabarro', *BMJ*, Oct. 11, 1958, p. 919.

¹⁴⁷ They include, James Purves Morison Purves-Stewart who wrote *Nerve Injuries and their Treatment* with Arthur Evans. Anon, James Purves Morison Purves-Stewart, *Lancet*, June 25, 1949, p. 1122 and Thomas Grainger Stewart who co-authored a textbook of Nervous Diseases with William Aldren Turner, Anon, 'Thomas Grainger Stewart', *Lancet*, Mar. 30, 1957, pp. 693-94.

on *Surgery of the Diseases of the Appendix Vermiformis*, which was published in 1904. It was popular and considered a useful clinical handbook.¹⁴⁸ Harold William Wilson co-authored *The Moveable Kidney: Its Pathology, Symptoms, and Treatment* with Dr. Conrad Meredyth Hinds Howell.¹⁴⁹ Other Harley Street practitioners who co-authored books included Edward Woakes, a specialist in diseases of the throat, who published his fourth edition of *On Deafness, Giddiness, and Noises in the Head* with his son Claude Woakes, also a Harley Street practitioner.¹⁵⁰

Members of the cohort also teamed up with non-Harley Street practitioners. Wilson's name is particularly associated with the textbook *Surgery*, published in 1920, which he edited with Professor George E. Gask. The book contained the work of various authors and was considered an important contribution to medical knowledge. George Lenthal Cheate published the results of his research into breast cancer in collaboration with Max Cutler in *Tumours of the Breast*, and Philip Henry Pye-Smith was joint author with Dr. Fagge of the popular *Textbook of the Principles and Practice of Medicine*, which reached its fourth edition in 1901.¹⁵¹ Collaboration on articles was less common for the group. In addition to his many contributions to medical journals the surgeon, Stanley Boyd was one of the few who co-authored an article when he wrote "Cancer of the Mouth

¹⁴⁸ Anon, 'Battle', p. 341.

¹⁴⁹ Published in 1908, Anon, 'H.W. Wilson', *BMJ*, Nov. 28, 1959, p. 1184.

¹⁵⁰ Anon, 'Edward Woakes', *Lancet*, Oct. 12, 1912, p. 1047.

¹⁵¹ Anon, 'George Lenthal Cheate', *Lancet*, Jan. 13, 1951, p. 115. Anon, 'Philip Henry Pye-Smith', *Lancet*, May 30, 1914, p. 1578. Others included Ernest Rock Carling who was joint editor with Sir James Paterson Ross on *British Surgical Practice*. Anon, 'Sir Ernest Rock Carling', *BMJ*, July 23, 1960, p. 313.

and Face", with W. H. Unwin, which was published in the *Practitioner* in 1903.¹⁵²

A large number of the cohort contributed to general dictionaries of medicine and manuals and some of the editors were Harley Street men. The most popular were: *Quain's Dictionary of Medicine*, (first edition 1882), Allbutt's *A System of Medicine* (first edition, 1896) followed by *Fowler's Dictionary of Medicine*, *Allchin's Manual of Medicine*, the *Practitioners' Encyclopaedia of Medicine and Surgery*, the *Dictionary of Practical Medicine* and *Choyce's System of Surgery*.¹⁵³

Sir Richard Quain, Royal Physician and assistant physician to the Hospital for Consumptive Diseases, spent seven years editing, and contributing articles on heart disease to his *Dictionary of Medicine*.¹⁵⁴ He enlisted the support of a significant number of his colleagues from Harley Street, most of them prominent medical writers, in the preparation of articles for the book. In total, 20 per cent of the contributions were from Harley Street men, including Quain's assistant editors Frederick Thomas Roberts, physician to UCH and to the Brompton Hospital and John Mitchell

¹⁵² Although Boyd did not publish a treatise on surgery, he regularly edited books on a variety of medical subjects such as seventh edition of Dr T.H. Green's *Pathology and Morbid Anatomy* Anon, 'James Stanley Newton Boyd', *Lancet*, Feb. 12, 1916, p. 376.

¹⁵³ *A System of Medicine, by Many Writers*, Thomas Clifford Allbutt, (ed.), Vols., 1896-1905 and from Vols. 1906-1911, Thomas Clifford Allbutt and Humphry Davy Rolleston eds., (London, 1896-1911). R.H.A. Whitelocke was regarded as a specialist on sports injuries and contributed to the *Practitioners' Encyclopaedia of Medicine and Surgery*. Anon, 'R.H.A. Whitelocke', *BMJ*, Nov. 26, 1927, p. 1009. Contributors to *Dictionary of Practical Medicine* included the ENT surgeon, John Gay French (1923). Anon, 'John Gay French', *Lancet*, Apr. 28, 1951, p. 969. An example of a contributor to *Choyce's* was Ernest Rock Carling, a specialist in radiology.

¹⁵⁴ The first publication in 1882 sold 30, 000 copies and was followed in 1894 by a second edition. Brown, *Fellows*, 1851, p. 64.

Bruce, physician to Charing Cross Hospital.¹⁵⁵ The significance of articles in these medical compilations was that they were written by leading authorities in their fields, including Edmund Parkes, Reginald Langdon Down and Arthur Ernest Sansom. Sansom, for example, was regarded as one of the foremost authorities in heart disease and like many leading authorities in their subject published in both *Quain's* and *Allbutt's*.¹⁵⁶

Like so many aspirant consultants, Humphry Rolleston gave lectures. In his capacity as demonstrator of pathology, physiology, and anatomy in Cambridge, he became acquainted with Sir Clifford Allbutt (1836-1925), the Regius Professor at Cambridge who had been a friend of his father, the Linacre Professor of Physiology at Oxford, George Rolleston (1829-1881). Allbutt asked Humphry Rolleston to work on the *System of Medicine* and Rolleston played a considerable role in its preparation: he contributed a number of articles, which ranged from alcoholism to diseases of the spleen and by the second volume he was made co-editor.¹⁵⁷ A considerable number of Harley Street practitioners contributed to various editions of Allbutt and Rolleston's *A System of Medicine* (1906-1911). Each volume was devoted to specific medical conditions: the percentage of contributors from Harley Street ranged from 15 per cent in 1907 (for articles on insect and animal

¹⁵⁵ Others included William Squire, Sir Raymond Crawford, Henry Radcliffe Crocker, Arthur Ernest Sansom, James Stanley Boyd, Reginald Langdon-Down and Herbert Thomas Herring. Of the contributors to the third edition of *Quain's*, 57 out of the 284 were from Harley Street, for a list of contributors see *Quain's Dictionary of Medicine*, third edition, H. Montague Murray, John Harold and W. Cecil Bosanquet, eds., (London, 1902), pp. ix-xviii

¹⁵⁶ Anon, 'Arthur Ernest Sansom', *Lancet*, Mar. 23, 1907, p. 842. Others included the ophthalmic surgeon John Tweedy (later Sir and President of the RCS).

¹⁵⁷ The first edition of the eight-volume work appeared in 1898-9. Scott Stevenson, *Harley Street Mirror*, p. 22-23. Rolleston's name appeared in the revised edition along with Allbutt's in 1906-11. Anon, 'Sir Humphry Rolleston', *BMJ*, Sept. 30, 1944, p. 452. Rolleston later wrote monographs on subjects such as the diseases of the liver and endocrine glands.

parasites and tropical diseases) to 62 per cent for the volume concerned with *Diseases of the Skin* (1911). The latter featured a large number of articles from Thomas Colcott Fox plus articles from other Harley Street medical practitioners such as Phineas Simon Abraham, Sir Malcolm Morris, John MacLeod Hendry MacLeod, Arthur Whitfield and James Harry Sequeira.¹⁵⁸

Harley Street and the rise of Specialist Journals

London was the most fertile area for specialist societies in Britain and so too was it the breeding ground for specialist publications, as the two were often linked.¹⁵⁹ In addition to contributing articles based on their special interests, a number of Harley Street men such as Robert Knox and Richard Norris Wolfenden were instrumental in launching new journals, particularly specialist journals, which became increasingly common from the 1870s onwards.¹⁶⁰ Knox was editor of *British Journal of Radiology* and co-founder and President of the British Association of Radiology and Physiotherapy (1920-1924).¹⁶¹ He was well known internationally for his speciality and it was largely due to his proposals that the International Congress of radiology was held in London in 1925.¹⁶²

Wolfenden, a physician with a special interest in laryngology, founded the *Journal of Laryngology and Rhinology* in 1887 together with

¹⁵⁸ Other contributors included Henry Head who wrote on diseases of the nerves, Arthur Ernest Sansom who wrote on diseases of the heart and Harold Batty Shaw who contributed articles on food poisoning and osteo-arthritis.

¹⁵⁹ M. Jeanne Peterson, 'Specialist Journals and Professional Rivalries in Victorian Medicine', *Victorian Periodicals Review*, Vol. 12, Number 1, Spring 1979, p. 29.

¹⁶⁰ Bynum and Wilson, 'Medical Journals and Medical knowledge', in W.F. Bynum, Stephen Lock and Roy Porter, eds., *Historical Essays*, (London, 1992), p. 33.

¹⁶¹ He was also the editor of the *Archives of Radiology & Electro-Therapy*. The other founder was Sir Archibald Reid.

¹⁶² Anon, 'Robert Knox', *Lancet*, Sept. 29, 1928, p. 681.

Morell Mackenzie.¹⁶³ With the growing interest in the study of nervous diseases during the First World War and the development of psychopathology as a new science, Samuel Alexander Kinnier Wilson recognised the need for a new journal, which could represent the views of these specialists.¹⁶⁴ Since the publication of *The Review of Neurology and Psychiatry* had ceased during the war he founded the *Journal of Neurology and Psychopathology* in 1920 and became its editor.¹⁶⁵ Wilson remained in the post when the *Journal* was taken over by the BMA in 1926 where he continued as editor until his death in 1937.¹⁶⁶ Other Harley Street editors of specialist journals included the expert in nervous diseases, Maurice Nicoll, who was co-editor of the *Journal of Neurology and Psychopathology* from 1922 to 1932.

Sir Gordon Holmes's original research into neural disorders was widely published in the *Lancet*, *BMJ* and *Brain*. Like many of his Harley Street contemporaries, Holmes presented the Goulstonian and the Croonian lectures and he received a number of awards and medals for his research including the Conway prize of the Royal College of Physicians.¹⁶⁷ He was awarded the gold medal from the RSM and was appointed Hughlings Jackson lecturer at the RSM in 1955. Holmes became editor of *Brain* (1922-

¹⁶³ The *Journal* continued as the *Journal of Laryngology, Rhinology and Otology* in 1921. See also, Anon, 'Richard Norris Wolfenden', *Lancet*, Nov.13, 1926, p. 1036.

¹⁶⁴ Anon, 'S. A. Kinnier Wilson', *BMJ*, May 22, 1937, p. 1095.

¹⁶⁵ In 1937, the *Journal* continued as the *Journal of Neurology and Psychiatry*.

¹⁶⁶ William Munk et al, *The Roll of the Royal College of Physicians of London*, (London, 1914), p. 540 and Anon, 'Wilson', p.1095.

¹⁶⁷ F. M. R. Walshe, (ed.), *Selected Papers of Sir Gordon Holmes*, (London, 1956), p. v. Holmes also delivered the Montgomery Lectures on Ophthalmology in Trinity College Dublin in June 1919, which "established him as a major figure in neurology". See Davis Coakley, *Irish Masters of Medicine*, (Dublin, 1992), p. 258.

1937) and collaborated in the writing of papers with other Harley Street physicians who had a special interest in neurology such as Henry Head and Frederick Eustace Batten. Batten's work as a specialist in neurology at the National Hospital, Queen Square, was honoured when the hospital named the Batten Unit after him.¹⁶⁸

In 1911, Holmes and Head wrote 'Sensory disturbances from Cerebral Lesions' which was the result of five years research into the function of the thalamus in relation to the cerebral cortex and was described as the "first systematic account" on the subject.¹⁶⁹ Holmes and Batten also collaborated on a paper, which they presented to the RSM in 1908, 'on the nervous system of a dog'. Thomas Dixon Savill who specialised in dermatology in addition to neurology wrote a book on neurasthenia (a disease of the nervous system which caused depression and insomnia), which ran to four editions, and his *System of Clinical Medicine* was considered an original contribution to the subject.¹⁷⁰

After returning from his post as Dean of the Hong Kong College of Medicine for Chinese in 1897, James Cantlie founded the *Transactions of the Royal Society of Tropical Medicine and Hygiene* and became its editor. He later established the monthly *Journal of Tropical Medicine*, devoted to surgical and gynaecological work in the Tropics, and became one of the *Journal's* first joint editors.

¹⁶⁸ Hunting, *RSM*, pp. ix and 265. Holmes also collaborated with Thomas Grainger Stewart on "Symptomatology of Cerebellar Tumours: A Study of Forty Cases".

¹⁶⁹ Coakley, *Masters of Medicine*, p. 256.

¹⁷⁰ Anon, 'Thomas Dixon Savill', *BMJ*, Jan. 22, 1910, p. 238.

Not all of those practicing a particular speciality wanted to be wholly identified with it. The physician James Purves Morison Purves-Stewart, practiced at Westminster Hospital where he later became consulting physician. He was elected President of the neurological section of the RSM and he wrote extensively on neurology including the popular *Diagnosis of Nervous Diseases*. Despite the fact that he had "little interest outside neurology", he liked to be seen as a generalist, for his obituarist stated that "his all-round ability suited him for the role of general physician, and indeed he was at some pains to assert that as senior physician to a teaching hospital he should be so regarded".¹⁷¹

Once paediatrics had become a recognised speciality at the end of the nineteenth century, a number of physicians including Horatio Bryan Donkin wrote textbooks on the subject.¹⁷² Donkin, who was a physician to the East London Hospital for Children, published *Diseases of Childhood* in 1893. Despite his interest in paediatrics, he wrote on a range of subjects including mental disease, psychology and crime; moreover, his interest in the prevention of venereal disease encouraged him to establish a society to deal with the subject.

Two years before his arrival in Harley Street in 1901, George Frederic Still (later Sir) was appointed physician for diseases at King's College Hospital: this was the first teaching hospital to open a special department

¹⁷¹ Anon, 'James Purves Morison Purves-Stewart', *Lancet*, June 25, 1949, p. 1122.

¹⁷² For further details see Elizabeth M. R. Lomax, 'Small and Special: The Development of Hospitals for Children in Victorian Britain', *Medical History*, Supplement No. 16, (London, 1996), p. 170.

for children's diseases. Much of the material in his well-known textbook *Common Diseases in Children* (1909) was based on the lectures he gave at King's.¹⁷³ Since "important contributions to the understanding of children's disease [were] presented at the meetings of the RMCS", Still presented his papers on juvenile rheumatoid arthritis to the society and published in the society's *Transactions* (1897 and 1903).¹⁷⁴ In addition, Garrod and Batten's *Diseases of Children*, included contributors with a special interest in paediatrics such as Arthur Francis Voelcker, who was a physician at the Hospital for Sick Children, Great Ormond Street.¹⁷⁵

Conclusion

The publication of innovative ideas exerted tremendous influence on establishing the success of several of the group. For those who expected to build a consultancy practice, it was a necessary adjunct to their professional experience. James Mackenzie moved to Harley Street from his GP practice in Burnley following the publication of *The Study of the Pulse* (1902) and *Diseases of the Heart* (1908). These monographs established his career as a cardiologist and from 1912 he built a large and successful consulting practice in Harley Street.¹⁷⁶ Whilst Mackenzie's first year in London brought him £114 in fees, by his second year, following the publication of *Diseases of the Heart*, he earned over £1,000. Mackenzie attributed this

¹⁷³ Anon, 'Sir Frederick Still', *BMJ*, July 12, 1941, p. 69.

¹⁷⁴ Hunting, *RSM*, pp. 309-310.

¹⁷⁵ Anon, 'Arthur Francis Voelcker', *BMJ*, June 22, 1946, p. 969.

¹⁷⁶ Anon, 'Sir James Mackenzie', *BMJ*, Jan. 31, 1925, pp. 242-245.

exceptional change of fortune "to my book".¹⁷⁷ Similarly, publication was also fundamental in establishing the career of Robert Brundell Carter who, "up to the age of 40" had been "a conspicuously unsuccessful general practitioner in the country".¹⁷⁸ In 1854, he had served as a surgeon in the Crimean War and the letters that were published during his military experiences "had a great future influence on his career", as it brought him to the attention of the editorial staff of the *Times* and the *Lancet*. In 1869, at the age of 41, Carter came to London to join the staff of the *Times* where he later became one of its leading writers. Besides his work for the *Times*, he wrote regular columns in the *Lancet*. The following year in 1870, Carter became an ophthalmic surgeon to St. Georges' Hospital and on his retirement in 1893, he became consulting ophthalmic surgeon.

For those who wanted recognition as specialists abroad, publishing was essential. On the strength of his publications, James Mackenzie's reputation extended well beyond the UK.¹⁷⁹ James Purves-Stewart remarked on the "serious matter" of writing articles for the medical press both at home and overseas. He claimed that it was on the basis of these articles and the publication of his popular text-book *Diagnosis of Nervous Diseases*, which was translated into various foreign languages, that he built an extensive consulting practice with patients both from England and abroad. His publications reached a wide medical audience and "European,

¹⁷⁷ R. Macnair Wilson, *The Beloved Physician: Sir James Mackenzie*, (London, 1926), p. 197.

¹⁷⁸ Anon, 'Robert Brundell Carter', *Lancet*, Nov. 2, 1918, p. 607.

¹⁷⁹ See, James Purves-Stewart, *Sands of Time: Recollections of a Physician in Peace and War*, (London, 1939), p. 104.

transatlantic and antipodean neurologists gave it a warm welcome". Consequently, he received the chair of neurology at a medical college in San Francisco in 1905 and was elected as an honorary member to various foreign medical societies.¹⁸⁰

As mentioned earlier, William Jenner's clinical study of fever at the London Fever Hospital identified typhoid and non-typhus fevers. His reputation was established by the publication of this work and he was offered the position of Professor of Pathological Anatomy at University College London. He contributed regularly to such medical journals as *British and Foreign Medico-Chirurgical Review* and the *Medical Times and Gazette*, and was for a time editor of the latter. However, he did not retain this position for long partly because of the demands of a very large consulting practice and because he "relinquished work which he did not find altogether congenial". Therefore, he did not write a great deal in his later years, with the exception of his lectures¹⁸¹

There were a small number of Harley Street practitioners, who did not confine themselves to writing on medical or scientific subjects.¹⁸² The publications that displayed varied interests included Percival Macleod Yearsley's diverse writings, which incorporated fairy tales and the role of

¹⁸⁰ *Ibid.*, pp. 99, 102, 222. His book reached its eighth edition in 1937.

¹⁸¹ His lectures: *Lectures and Essays on fevers and Diphtheria* and *Clinical Lectures and essays on Rickets, Tuberculosis, Abdominal Tumours and other Subjects* were published in two volumes in 1893 and 1895, after he left Harley Street. Anon, 'Sir William Jenner', *BMJ*, Dec. 17, 1898, pp. 1849-1853.

¹⁸² For example, following his retirement from practice, Sir William Hale-White wrote *Great Doctors of the Nineteenth Century* (London, 1935) and *John Keats as Doctor and Patient*, (New York (etc), 1938). Anon, 'Sir William Hale-White', *BMJ*, Mar. 5, 1949, p. 415.

doctors in Elizabethan drama and those from the physician Raymond Crawford on the history of medicine.¹⁸³

In general, there was no financial reward for publishing articles in the *BMJ* or the *Lancet*. Only those who were commissioned to write the leading article were paid, as were the assessors who evaluated particular contributions to the journals.¹⁸⁴ Thus, professional advancement rather than financial reward was one of the main reasons the cohort published, particularly at the start of their careers, as publication gained the attention of the senior hospital staff. Sir Humphry Rolleston fits this model; he published *A Manual of Practical Morbid Anatomy* following his post as house-physician and demonstrator of anatomy at Bart's, while he was waiting for a full-time position on the staff of that hospital. As the cohort proceeded in their professional life, publication was a method of communicating the results of their research to colleagues, which, in turn, established their reputation as leading figures in their fields and led to increasingly successful consultancy practices.

As Bynum and Wilson remarked, occupational pluralism was the norm for the medical practitioner in Victorian Britain.¹⁸⁵ This was certainly true of the Harley Street élite and was typified by Donald Armour who specialised in neuro-surgery. Not only did he have a large private practice, but he was appointed president or held a senior role in every medical society

¹⁸³ Anon, 'Percival Macleod Yearsley', *Lancet*, May 19, 1951, p. 1130 and Anon, 'Sir Raymond Crawford', *Lancet*, Mar. 19, 1938, p. 697.

¹⁸⁴ Paul Ferris, *The Doctors* (London, 1965), p. 68.

¹⁸⁵ Bynum and Wilson, 'Periodical Knowledge' in Bynum et al, *Medical Journals*, p. 41.

to which he belonged; moreover, he was a prolific writer and contributed a large number of articles to the medical press, delivered the Lettsomian Lectures, and was appointed Arris and Gale lecturer.¹⁸⁶ A number of the cohort had a similar profile to Armour: many held senior positions or were active in medical societies, the majority published their work and the most distinguished physicians or surgeons delivered one or more of the eponymous or memorial lectures. In addition, medical practitioners who could not draw on private incomes, and who wished to develop a consulting practice were frequently forced to spread their activities across a range of part-time appointments in teaching, writing and research, as full time positions were not common.¹⁸⁷ The demands of a busy practice, however, left a small minority of the cohort little time for writing or attendance at medical societies.¹⁸⁸ Not publishing one's work or not participating in professional societies did not necessarily impede professional development, but those such as Joseph John Perkins, physician to St. Thomas's Hospital who became a well-known expert on pulmonary disease and built an extensive Harley Street practice, *despite* publishing little and not being a member of professional societies, were an exception.¹⁸⁹

¹⁸⁶ Armour was President of the Neurological Section of the RSM, the West London Medico-Chirurgical Society, the Medical Society of London, of the Association of British Neurological Surgeons and President of the BMA Section of Neurology and Psychological Medicine. Anon, 'Donald Armour', *BMJ*, Nov. 4, 1933, p. 847.

¹⁸⁷ An example of this was Thomas Jeeves Horder, Anon, 'Lord Horder of Ashford' *BMJ*, Aug 27, 1955, p. 565.

¹⁸⁸ This was particularly true later in their careers when they had built up a large practice, see for example, Anon, Sir Charles Ryall, *BMJ*, Sept. 16, 1922, p. 534 and Anon, 'Sir William Jenner', *BMJ*, Dec. 17, 1898, pp. 1849-1853.

¹⁸⁹ Italics mine. Anon, 'Joseph John Perkins', *BMJ*, Sept. 22, 1928, p. 550.

Regardless of Jeanne Peterson's claim that there was "no formal rule of 'publish or perish' in the nineteenth-century medical life", the majority of Harley Street medical practitioners upheld this maxim implicitly.¹⁹⁰ It may thus be argued that the group's publications and collective editorial power enabled them to professionalise the discipline of medicine and more specifically, that the many areas of specialised medicine, which so many of these men created during their time in Harley Street, contributed significantly to the advancement of medicine in Britain in the late nineteenth and early twentieth centuries. It seems unlikely that they would have achieved their professional eminence if they had not followed the tacit (admittedly American) dictum of "publish or perish".

¹⁹⁰ M. Jeanne Peterson, 'Specialist Journals and Professional Rivalries in Victorian Medicine', *Victorian Periodicals Review*, Vol. 12, Number 1, Spring 1979, p. 30.

CHAPTER 7

Women Medical Practitioners of Harley Street

Introduction - The Role of Women in Victorian Britain

In mid-nineteenth century Britain, the idea of a woman's place was underpinned by legal, political and social practices that subordinated women.¹ Victorian middle class femininity was structured around perpetually diseased and weak bodies, based upon the assumed dominance of an unstable female reproductive apparatus. Katharina Rowold has argued that the so-called women's question, intensely debated by many physicians and scientists in the nineteenth century, was centred on the Victorian concept of "nature" that emphasised gender differences.² Victorian women faced unrelenting obstacles from the medical profession in their attempt to establish a career in medicine. Nineteenth Century physicians upheld an ideology that conferred on women such traits as being passive, pious, pure and domestic and believed that women were physically and intellectually inferior.

Henry Maudsley (1835-1918) argued in 1874 that women could never hope to match masculine achievements because physiology acted as a handicap: their body and mind were for "one quarter each month more or

¹ Under common law, married women did not have an identity outside that of their husband's. see, Trevor May, *An Economic and Social History of Britain, 1760-1990*, (Essex, 1996), p. 284.

² Katharina Rowold, (ed.), *Gender and Science, late Nineteenth-Century Debates on the Female Mind and Body*, (Bristol, 1996), pp. ix-xxxv.

less sick and unfit for hard work".³ Women doctors fought back, disputing the notion that higher education was injurious to the female mind and body.⁴ Elizabeth Garrett Anderson rebuked Maudsley for claiming that advocates of education for women were endeavouring "to assimilate the female to the male mind".⁵ In the face of such trenchant opposition, Maudsley had, by 1878, altered his view of higher education for women, as he felt that the "women's movement must sooner or later have its day".⁶ Consequently, he proposed an amendment to the RCP charter that would allow women medical students to obtain a licence from the College, provided they met the required academic standards.

The impetus for higher education began in the 1860s, when women also began to want to study medicine. Supporters of women's education argued that their caring and nurturing aspects combined with the desire of some women patients to be seen by a female medical practitioner, made women well suited for this role.⁷ It was not until the late nineteenth century, with the rise of the professional, meritocratic middle class, that women could accept salaried posts and thus undertake work normally attributed to men (bureaucratic, clerical or medical).

³ Henry Maudsley, 'Sex in Mind and Education', *The Fortnightly Review*, 1874, Vol. 15, pp. 466-83.

⁴ Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980*, (London, first edition 1985, this edition 1988), pp. 124-126.

⁵ Elizabeth Garrett Anderson, 'Sex in Mind and Education: a Reply', *The Fortnightly Review*, 1874, Vol. 16, pp. 506-517. Also see Rowold, *Gender*, pp. 54-77.

⁶ A. M. Cooke in *The History of the Royal College of Physicians of London*, Vol. 111, (Oxford, 1972), p. 834.

⁷ Rowold, *Gender*, p. xiii

Hitchin College (later Girton) and Merton Hall, (later Newham College) were founded for women in Cambridge in 1869 and 1871 respectively, and women could attend lectures, but until 1922 they only received "certificates of degrees" with no letters after their name. Women were not admitted to full membership at Oxford until 1920 and at Cambridge until 1947.⁸ By 1914 an English woman could operate in a far wider sphere than she could have done a century earlier; yet, though she was a person in her own right, she was still not equal to men. Five years later, Parliament passed a Sex Disqualification (Removal) Act, which declared that no one should be disqualified from holding office or civil or judicial posts by their sex.⁹

Women's education was inevitably linked to their position in society. Middle and upper class girls were typically educated at home by a governess, until they were approximately 10 years old. After this, they attended day or boarding schools.¹⁰ Between 1864-1868, the Schools Inquiry Commission (Taunton Commission) examined the status of education in endowed and proprietary schools. The Commission found that there was little difference between men and women's mental abilities; moreover, it also reported that there were only 13 secondary schools for girls in the country.¹¹ Although a few schools had opened for girls in London in the late 1840s and 1850s, which focused on academic achievement, progress moved

⁸ Women were admitted to degrees in Edinburgh, Glasgow, St Andrews and Aberdeen in 1892.

⁹ Joan Perkins, *Victorian Women*, (London, 1993), p. 243.

¹⁰ Perkins, *Victorian Women*, p. 32.

¹¹ PRO, File HC 1867-8 xxviii, quoted in *Ibid*.

at a rather slow pace and there was no state-sponsored system of free schools until 1870.¹²

The First Generation of Women Medical Practitioners

The women who eventually set up practice in Harley Street owed much to the earliest female medical practitioners. As is well known, Elizabeth Blackwell (1821-1910) who qualified as a MD from Geneva College, New York in 1849, was the first woman to be listed in the English *Medical Register* in 1859. Nevertheless, this move fuelled much opposition as the GMC refused, thereafter, to admit medical practitioners with foreign degrees to the *Medical Register*. In practice, this meant *all* women, as they could not qualify in England.

The second woman to be included was Elizabeth Garrett (1836-1917), later Garrett Anderson, in 1866. She began her medical studies in 1860 and was the first woman to hold a diploma from an English licensing body. Since London teaching hospitals were closed to female students, she was compelled to pay for private tuition in London and pursued her studies at St Andrews and Edinburgh.¹³ The 1858 Medical Act stipulated that those listed in the *Medical Register* had to receive their diploma, degree or a licence from one of the 19 prescribed Examining Boards. Only the Society of Apothecaries accepted Elizabeth Garrett who was granted the LSA in 1865,

¹² Perkins, *Victorian Women*, p. 253. Queen's College for Women in Harley Street was founded in 1848, Bedford College in 1849 and North London Collegiate School was founded in 1850.

¹³ Catriona Blake, *The Charge of the Parasols: Women's Entry to the Medical Profession* (London, 1990), pp. 61 and 216. Elizabeth Garrett was given permission by the Apothecaries Society to take private lessons from the lecturers of recognised medical schools. See Mary Scharlieb 'Women in the Medical Profession: An address' (London, 1898), p. 9.

thus, entitling her name to appear on the *Medical Register* a year later. However, in an effort to preclude more women from taking its diploma, the Society of Apothecaries introduced a ban on private education and stipulated that students had to graduate from one of the approved list of medical schools, all of which were closed to women. Although women could, and some did, practise without a recognised qualification, their exclusion from the *Register* was deemed iniquitous by a group of astute women led by Sophia Jex-Blake (1840-1912).¹⁴ After Jex-Blake found that no British university would grant women medical degrees she resolved to set up her own institution and opened up an office in Wimpole Street in 1874. Although Garrett Anderson and Blackwell were initially reluctant to associate with such an outspoken individual, eventually they supported her. Various eminent male medical practitioners and scientists lent their support including Ernest Hart, Thomas Henry Huxley (1825-1895) and John Burdon-Sanderson (1829-1905). Eventually, Jex-Blake found suitable premises in Henrietta Street, Brunswick Square and opened the London School of Medicine for Women (LSMW) on 12 October 1874, with 14 students.

The only examining body that would admit women was the King's and Queen's College of Physicians in Ireland, which allowed women to sit their Licentiate (LKQPI) and the Licentiate in Midwifery (LM). Six women sat the first examination, including Jex-Blake, Isabel Thorne and Edith

¹⁴ Blake, *Parasols*, p. 20, Blake argued that Louisa Atkins, Edith Pechey and Eliza Walker built up successful practices based on their foreign degrees.

Pechey and three who were protégés of Garrett Anderson. However, they were unable to obtain clinical instruction and hospital practice until the LSMW formed an alliance with the Royal Free Hospital, which meant they could be listed in the *Medical Register*. It was not until December 1877 that the Convocation of London University agreed to change the University Charter and voted for the admission of women to all degree examinations. Women could finally take their medical degrees in England and set up practices throughout the UK.

By the end of the nineteenth century, the majority of London based female medical practitioners established their practices in West London, as did their male counterparts, while south-west and south-east London were the next most popular areas, see Table 7.1 Appendix F. In 1899, only three women had consulting rooms in Harley Street; nonetheless, the Harley Street Area, including Wimpole Street, Queen Anne Street and Welbeck Street, was the most popular region in the West End for women to establish a practice.¹⁵ Upper Berkeley Street in Mayfair also attracted a small satellite group of women, perhaps because of Elizabeth Garrett Anderson's presence, though of the four women practising there, two would later move to Harley Street.¹⁶ Likewise, of the five who practised in Nottingham Place, at least one would move to Harley Street.¹⁷

¹⁵ L.M.H., *The Englishwoman's Year-Book and Directory to all Institutions Existing for the Benefit of Women and Children*, (London, first edition 1888, this edition 1899), pp. 100-102

¹⁶ In 1905, Louisa Garrett Anderson moved to Harley Street, as did Agnes F. Blackadder (later Savill) in 1908.

¹⁷ This was May Thorne in 1905.

Mary Ann Elston found that much of the historiography on women and medicine in the Victorian period was shaped by the belief that the medical profession was almost exclusively male.¹⁸ This outlook perpetuated the claim, made by some historians, that female medical practitioners were virtually non-existent before the start of the Great War, despite the fact that by 1911, there were 610 women who worked in the medical profession and by 1914, 24 medical women practised in Harley Street.¹⁹ Elston distinguished between the first generation of women on the *Medical Register*, as those who qualified before the 1886 Medical Act and the second generation, as those who qualified after 1886.²⁰ This distinction is adopted here in comparing Harley Street women with other female medical practitioners.

Elston found that women accounted for only approximately one per cent of active medical practitioners up to the end of the nineteenth century, and that by 1921 their numbers had reached five percent.²¹ Despite the dearth of women medical practitioners up to 1914, the primary published and archival sources available for the distinguished female medical practitioners were rich and extensive. Even though "the subject of women's entry to the medical profession has received considerable historical attention over the years", as James Stuart Garner remarked recently, most of the scholarship on women in medicine emphasises the obstacles

¹⁸ Mary Ann Elston, 'Women Doctors in the Health Services: a Sociological Study of their Careers and Opportunities' (Ph.D. thesis, University of Leeds, 1986), pp. 1 and 63.

¹⁹ M. Jeanne Peterson, in *Medical Profession*, (London, 1978), p. 2, stated that "few women managed to enter the profession during the Victorian era".

²⁰ Elston, 'Women Doctors', p. 165.

²¹ *Ibid.*

encountered by the first women on the *Medical Register*.²² Historians have also examined the demand for women doctors in Colonial India and the opportunities that the First World War offered to them.²³

Although there exists a substantial body of scholarship on female medical practitioners in Britain and her Empire, the role of women medical practitioners in Harley Street has been completely neglected. This chapter seeks to redress that imbalance. Since the Harley Street cohort was a very small group, three of whom, Mary Scharlieb, Jane Walker and Charlotte Louisa Ellaby, were of the first generation, it was possible to undertake a more thorough analysis of their education and careers than it was for their male colleagues. The Harley Street women examined in this chapter (24 in all) are listed in Table 7.2 Appendix F.

Harley Street and Women Medical Practitioners

Elizabeth Garrett Anderson's decision to pursue a career in medicine was greeted with hostility by the men in Harley Street. When Garrett Anderson

²² James Stuart Garner, 'The Great Experiment: The Admission of Women Students to St Mary's Hospital Medical School, 1916-1925', *Medical History*, Vol. 42, Number 1, Jan. 1998, pp. 68-88. See, for example, Rebecca Baker, *The First Woman Doctor, the Story of Elizabeth Blackwell, M.D.* (London, 1946), Louisa Garrett Anderson, *Elizabeth Garrett Anderson, 1836-1917*, (London, 1959), Jo Manton, *Elizabeth Garrett, M.D.*, (London, 1960). For a general history of the medical women's struggle, see for example, E. Moberly Bell, *Storming the Citadel: The Rise of the Woman Doctor* (London, 1953), Blake, *Parasols, passim*, Edythe Lutzker, *Women Gain a Place in Medicine* (London, 1969). Elston, 'Women Doctors', *passim*. For an analysis of the first medical graduates of Queen Margaret College, Glasgow and Jex-Blake, see Wendy Alexander, *First Ladies of Medicine* (Glasgow, 1987), see also Sophia Jex-Blake, *Medical Women, a Thesis and a History* (Edinburgh, 1886), M. Todd, *The Life of Sophia Jex-Blake*, (London, 1918) and Shirley Roberts, *Sophia Jex-Blake: A Woman Pioneer in Nineteenth Century Medical Reform*, (London, 1993).

²³ On India see Margaret Balfour, Ruth Young and Mary Scharlieb, *The Work of Medical Women in India* (Oxford, 1929) and D.C. Wilson *Palace of Healing: The Story of Dr Clara Swain, First Woman Missionary Doctor and the Hospital she Founded* (London, 1968). For a history of women's medical work during the war, see Flora Murray, *Women as Army Surgeons, being the History of the Women's Hospital Corps in Paris: Wimereux & Endell Street, September 1914- October 1919* (London, 1920).

arrived with her father, Newson Garrett, in Harley Street in June 1860 to seek advice on entry into the medical profession from “the leading medical consultants”, she was actively discouraged. According to her daughter, Louisa, “no one offered help or believed in her high aspiration. Some laughed, some were rude”. One consultant suggested that she pursue the nursing profession instead.²⁴ Despite Louisa’s claim, her mother did receive support from several Harley Street practitioners. George Harley helped Anderson with her studies, he “used to repeat his lecture to her privately, as she was not allowed to be a listener at his class”.²⁵ Others, such as George Buchanan, the chief medical officer and a Harley Street physician, supported women’s medical education and campaigned strenuously for the admission of women to degrees at the University of London.²⁶

As mentioned in Chapter Six, the Harley Street surgeon Arthur Trehorn Norton became a fervent advocate of women’s right to enter medicine. For other practitioners, such as John Langdon Down, support for women was, however, ambivalent. Langdon Down believed in women’s contribution to society and he supported female suffrage; moreover, the 1872 National Society for Women’s Suffrage convened in his house in Harley Street.²⁷ However, when Elizabeth Garrett Anderson petitioned the London Hospital in 1876 to allow women to be admitted to their medical classes, they were refused because mixing the sexes was deemed inappropriate.

²⁴ Louisa Garrett Anderson, *Anderson*, p. 50

²⁵ Mrs Alec. Tweedie, (ed.), *George Harley F.R.S. or the Life of a London Physician*, (London, 1899), p. 166.

²⁶ Anon, ‘George Buchanan’, *BMJ*, May 11, 1895, p. 1066.

²⁷ O Connor Ward, *John Langdon Down, 1828-1896: a Caring Pioneer* (London, 1998), pp. 163-64.

Subsequently, a request was made to hold separate classes for both sexes: Langdon Down, who was by then a physician in the London Hospital, opposed this application even though he had:

no grave objection to women entering the Church, Law or Medicine, still I am clearly of opinion that the scheme propounded is not a practical one ... and would be highly detrimental, if not ruinous to the school of the London Hospital.²⁸

Other Harley Street physicians such as Sir William Jenner and Charles West, were implacable in their opposition to women's entry into medicine. E. Moberly Bell remarked that Jenner "testified that he had but one dear daughter and he would rather follow her ... to the grave than allow her go through such a course of study".²⁹ When the Fellows of the Royal College of Physicians were asked to vote on women's admission to medicine in 1878, Sir George Burrows (a non-Harley Street practitioner) proposed a rejection of the motion, which was seconded by West. In 1894, West proposed the rejection of a second motion to admit women on the grounds that allowing women's entrance to medicine would result in "gravely modifying the mental and moral characteristics of women and the relation of the sexes to each other, thus in many respects revolutionising society".³⁰ Even as late as 1913, when women were qualifying as medical practitioners, the Harley Street physician and lecturer on psychological medicine at Bart's, Thomas Claye Shaw, "warned the modern woman that her new

²⁸ J. Langdon Down, *Mental Affections*, (London, 1887), quoted in Ward, *Down*, p. 164.

²⁹ Bell, *Storming the Citadel*, p. 103.

³⁰ Anon, 'Charles West', *Lancet*, Apr. 2, 1898, pp. 968 – 970. See also, *Charles West, Medical Women: A Statement and an Argument*, (London, 1878), *passim*.

activities in sport and independence in life would mar the beauty of her face, change her nature, and alienate male sympathy".³¹

When women arrived in Harley Street in 1888, all male-governed English medical schools and hospitals were closed to women. The only two universities in Britain and Ireland that would grant them a medical degree were the University of London and the Royal University of Ireland.³² In 1888 there were also only three medical schools open to women: the London School of Medicine for Women (72 students in that year), the Edinburgh School of Medicine (17) and the Royal College of Surgeons, Dublin (12).³³ Since the male-dominated medical profession did not recognise women as having a significant role in the profession, they were excluded from the International Medical Congress in London in 1881.³⁴ Despite this opposition, Mary Scharlieb had a career path marked by noteworthy achievements. Greta Jones has described Scharlieb, as "one of the most distinguished women of her generation".³⁵ She was one of the two first medical graduates of the University of London, graduating (MB and BS) in 1882, and was the first woman to win the gold medal and exhibition in obstetrics.³⁶

³¹ Anon, 'Thomas Clave Shaw' *BMJ*, Jan. 22, 1927, p. 169.

³² L.M.H., *Year-Book*, p. 188.

³³ *Ibid.*, pp. 192 and 197.

³⁴ Thomas Neville Bonner, *To the Ends of the Earth, Women's Search for Education in Medicine* (London, 1992), p. 61.

³⁵ Greta Jones, 'Women and Eugenics in Britain: the Case of Mary Scharlieb, Sloan Chesser, and Stella Browne', *Annals of Science*, Vol., 51, 1995, p. 486.

³⁶ The other female medical graduate in 1882 was Miss Edith Shove (MB London 1882). L.M.H., *Year-Book*, pp. 195-196.

Five years later, in 1887 and after working as a doctor in Madras, Scharlieb returned to Britain to study for a higher degree in medicine. She received the MD from the University of London and the MS in 1897 — being the first woman in Britain to secure these degrees.³⁷ In 1892, Scharlieb was appointed gynaecologist to the Royal Free Hospital and thus became the first female member of staff of any general hospital because, as *The Times* noted, “she was a great surgeon”.³⁸ When she died in November 1930, the newspapers eulogised her role as the “famous” and “pioneering” woman doctor.³⁹

Like Scharlieb, Charlotte Ellaby gained much of her experience in India. The government of Bombay appointed her as second physician to Edith Pechey in 1886 at the Cama Hospital for Women, where she later established “the special eye department”.⁴⁰ Another first generation Harley Street woman practitioner, Jane Harriett Walker, has been described as one of the pioneers of the open-air treatment of tuberculosis. She was also one of the founder members of the Medical Women’s Federation established in 1917.⁴¹ The creation of her sanatorium “while she was still in Harley Street was frowned upon by her fellow consultants, but she ignored criticism”.⁴²

³⁷ Jones, ‘Women and Eugenics’, pp. 481- 502.

³⁸ Anon, *The Times*, June 1, 1932, RFHSM PC, Book 7, part 2.

³⁹ ‘Jane Harriett Walker’, in the *Daily Mail*, Dec. 22, 1930, *The Times*, Dec. 22, 1930, *Daily Telegraph*, Nov. 22, 1930, *Morning Post*, Dec. 26, 1930, RFHSM PC, Book 7, part 2., are just sample of the many tributes to her.

⁴⁰ Anon, ‘Charlotte Ellaby,’ *BMJ*, May 29, 1909, p. 1335.

⁴¹ Anon, ‘Jane Harriett Walker’, *The Times*, Nov. 18, 1938, RFHSM PC, Book 8, part 1, and Anon, ‘Jane Harriett Walker’, *Lancet*, Nov. 1938, p. 1259.

⁴² Veronica F. Dawkins, ‘Jane Harriet Walker Ch, MD, LLD’ Wellcome, archives of the MWF, C.132, p. 3.

Walker, who “could be quite formidable”, had an indomitable spirit and she refused to be intimidated by her colleagues’ censure.⁴³

Of the second generation, Dr. Florence Stoney has, like Scharlieb and Walker, been described by a number of her colleagues as a pioneer and “ahead of her time”, particularly in relation to her expertise in radiology and electro-therapeutics.⁴⁴ One of Stoney’s colleagues remarked that, “pioneers need courage, and hers was outstanding”.⁴⁵ Two other Harley Street consulting surgeons who were described as pioneers were Maud Mary Chadburn and Eleanor Davies-Colley, both of whom founded the South London Hospital for Women in 1916.⁴⁶ Chadburn also established the Marie Curie Hospital in Hampstead in 1928.⁴⁷ Davies-Colley became the first woman to earn the FRCS in 1911 when the fellowship of the Royal College of Surgeons was opened to women. Other noteworthy practitioners included Mary Louisa Gordon, who was the first woman to be appointed inspector of prisons and assistant inspector of inebriate reformatories.⁴⁸

The Cachet of a Harley Street Practice

Mary Ann Scharlieb became the first registered female medical practitioner to set up practice in Harley Street in 1888, in a house shared initially with

⁴³ *Ibid.*

⁴⁴ Dr. J. R. Lee, ‘Florence Stoney’, *The Times*, Oct 8, 1932, and ‘Florence Stoney’ by Dr. Watson Smith for the BMA, *BMJ*, Oct 22, 1932, ‘Some Extracts from Various Obituary Notices of Florence A. Stoney, RFHSM.

⁴⁵ Anon, ‘Dr Amy Sheppard’, *The Times*, Oct 8, 1932, RFHSM PC, Book 7, part 2. Stoney was awarded the OBE for her work during the war. She was one of the first women doctors to be invited to work by the war office. She became head of radiology in the Fulham Military Hospital in 1915.

⁴⁶ Anon, *BMJ*, May 4, 1957, RFHSM PC, Book 8, part 2.

⁴⁷ *Ibid.*, and Anon, ‘Maud Mary Chadburn’, *Lancet*, May 4, 1957, p. 939.

⁴⁸ Anon, *Woman’s Medical Journal*, May 18, 1908, pp. 106-108.

Professor (later Sir) Edward Sharpey-Shafer (1850-1935).⁴⁹ Scharlieb joined the ranks of distinguished male consultants in Harley Street such as the throat specialist, Sir Morell Mackenzie at number 19, Sir Richard Quain, physician extraordinary to the Queen, in 1890, at number 67, and the expert on skin diseases, Sir Malcolm Morris at number 8. Arthur Trehern Norton, had moved to Harley Street in 1887 — a year before Scharlieb established her practice there. However, Scharlieb's address at number 149, which was at the extremity of Harley Street, reflected her position as someone who was on the outskirts of the medical fraternity. Although Scharlieb's practice was situated at the north end of the street, close to the Marylebone Road, she consoled herself with the fact that "the house bore the magic name and opened into the great professional thoroughfare".⁵⁰

By 1888, the number of qualified medical women on the *Medical Register* totalled 57 and of these, 23 were based in London. Of the London group, most were engaged in private practice; only a couple of these practitioners were school medical officers or involved with a philanthropic organisation. The rest were widely dispersed: over a third were resident abroad, and the majority of these were medical missionaries in India.

Approximately 80 per cent of the female cohort were in practice before arriving in Harley Street: most of these were based in West or West

⁴⁹ Sharpey-Shafer assistant professor of physiology at University College and lecturer on physiology at the LSMW offered Scharlieb a great deal of practical help, for instance, he and his wife looked after Scharlieb's children when she returned to Madras. See Jane Walker, 'Dame Mary Scharlieb' *BMJ*, Nov. 29, 1930, p. 937, Anon, 'Dame Mary Scharlieb', *Lancet*, Nov. 29, 1930, pp. 1211-1212 and Mary Scharlieb, *Reminiscences*, (London, 1925), p. 131.

⁵⁰ Scharlieb, *Reminiscences*, p. 131.

Central London, only two were recent graduates. The average age of the cohort when they arrived was 38.5; thus, they were well established in their medical careers.⁵¹ The move to Harley Street from another practice address represented the usual upward career progression, as was seen with the male medical practitioners. The majority of women stayed an average of 19 years in Harley Street, during which time they built up their private practices, and 38% ($n = 9$) of these either retired or died at their Harley Street address. A further 30% ($n = 7$) were at least 60 years old when they left Harley Street and may well have retired.⁵² Of the younger female medical practitioners, the war encouraged several to leave private practice and join the hospital corps.⁵³ Harley Street was the last practice address for the majority of this cohort. Since their medical careers followed the normal career trajectory of a medical practitioner, whose prosperity increased in later years, I am arguing that Harley Street represented the pinnacle of success in private practice for these medical women. Various newspapers in the early twentieth century reflected the prestige of practising in this area, referring to many of these women as the “women doctors of Harley Street fame”.⁵⁴

⁵¹ See Table 7.2, Appendix F, for details of their ages. Of the two recent graduates one, Mary Ethel Sim Scharlieb moved into her mother's practice address on graduation.

⁵² *The Medical Directory* does not always indicate whether a person is professionally inactive.

⁵³ Louisa Garrett Anderson left Harley Street to join the war effort in 1914. May Thorne did not return to her private practice in Harley Street following the war. Ada Stoney and Lilian Chesney also participated shortly after they left Harley Street.

⁵⁴ This comment was made at the jubilee of the LSMW in 1920 when the guest of honour Princess Louise was seated with “women doctors of Harley Street fame.” Present at the luncheon were “100 clever women entertain[ing] 100 clever men”, which included representatives from a variety of occupations, and at least 7 of the cohort, RFHSM PC, Book 5, pp. 183-185.

Since the first women to establish practices in this élite male environment were few in number, the development of a professional community for this group was examined to determine if they experienced the *professional* isolation, which the early twentieth century surgeon, Louisa Martindale, claimed was prevalent for female practitioners in English Edwardian provincial practice.⁵⁵ She argued that:

her chief disability—professional isolation, however, is a great and sometimes almost an overwhelming one, depending again on the tone and the spirit of the women of the provincial town in which she lives.⁵⁶

Jane Walker acknowledged such isolation in her 1922 address to students at the LSMW when she pointed out that women GPs led a “solitary life” in towns, where their male colleagues would outnumber them by a ratio of 20:1.⁵⁷ Martindale depicted uneasy social relations between differing professional ranks in the towns, and in particular with male colleagues. Thus, she found an “insurmountable wall of—is it jealousy or sex rivalry or, as I am more inclined to believe, a barrier due to the unconscious influence of doctors’ wives”.⁵⁸ She further remarked “everyone knows the distinguished and eminent women consultants in London at the present time”.⁵⁹ Martindale would certainly have included women such as Mary Scharlieb and Jane Walker in her evaluation. Women in an area such as Harley Street would have had more frequent social contact than their provincial counterparts. The referral system would have undoubtedly

⁵⁵ Louisa Martindale, *The Woman Doctor and her Future*, (London, 1922), p. 85

⁵⁶ *Ibid.*

⁵⁷ Anon, *The Times*, Oct. 2, 1929, RFHSM PC, Book 7, part 1, p. 165.

⁵⁸ Martindale, *Woman Doctor*, pp. 85-86.

⁵⁹ *Ibid.*

contributed to this. As Martindale also remarked these women “are sought after and called into consultation”.⁶⁰ Thus, Harley Street female medical practitioners appear not to have experienced the professional isolation that Louisa Martindale claimed medical women encountered in the provinces.

Motivation of the First Generation

From 1888 to 1914, the first and second-generation women practitioners in Harley Street pursued a career in medicine for different reasons. Whilst Mary Ann Elston stated that philanthropy, missionary work and financial independence constituted the main personal motivations for the first generation, I argue that this represents a partial explanation only and that the desire to satisfy their intellectual ability through the pursuit of medicine must also be taken into consideration, as this probably played a more significant role for these Harley Street women.⁶¹

The desire to nurture personal intellectual needs was so strong that self-education became an important pursuit for academically ambitious women. Mary Bird’s (later Scharlieb) acquisition of knowledge was typical of the early group of aspiring female doctors.⁶² Her aunt, who had taught her basic French and Latin, would also frequently accompany her to public lectures on science. So keen was her thirst for knowledge that Scharlieb virtually memorised Brewer’s *Guide to Science* and the *Child’s Guide to Knowledge*.⁶³ She later attended Mrs. Tyndall’s school in St John’s Wood

⁶⁰ *Ibid.*

⁶¹ Elston, ‘Women Doctors’, p. 173.

⁶² Isabel Thorne for example, studied daily from “6 a.m. to 8 p.m.” See, May Thorne, Granny Thorn’s Diary, 1834-1910, p. 5. Archives of the LSMW and the Royal Free.

⁶³ Scharlieb, *Reminiscences*, p. 4.

and once there felt “compelled to work hard” at German and found the science lectures “admirable”.⁶⁴ Following her secondary education, she took on the role of governess to her younger siblings whilst continuing her own intellectual pursuits with lectures, museum trips and private tuition. Even when she arrived in Madras with her husband, who was a barrister, she “did [her] best to keep up languages and mathematics”.⁶⁵ In addition to running the household, Scharlieb helped her husband with his legal work, which played a pivotal role in her career choice. When he asked her, in his capacity as editor, to review Sir Joseph Fayrer’s article on medical jurisprudence for the *Madras Jurist*, she found this “aroused [her] interest in medicine” and in 1871, she began to study midwifery.⁶⁶

Fayrer’s article was concerned with the plight of the Mahommedan and Hindu women, particularly in childbirth, who would not permit a male to attend them due to the strict rules of purdah. As there were no female medical practitioners in India at the time, these women were frequently left to the mercy of untrained midwives or they suffered alone. This situation left such an indelible impression on Scharlieb that she discovered her academic interest in medicine. Because of the desire to help these women, Scharlieb’s wish to study medicine was given a socially acceptable outlet. She vowed to put her “theoretical knowledge” into practice with the aim of bringing medical education to the women of India. Since missionary work was viewed as acceptable for women of Scharlieb’s generation, she faced less

⁶⁴ *Ibid.*, p. 8.

⁶⁵ *Ibid.*, p. 24.

⁶⁶ *Ibid.*, p. 29.

opposition from the medical profession than would have otherwise been the case. Though, Queen Victoria was not in favour of women doctors, she was, however, supportive of Scharlieb's efforts in India.⁶⁷

Scharlieb began training as a nurse at the Madras Lying-in Hospital and studied midwifery under surgeon-major Cockerill. She later persuaded her husband's professional contacts to lend their support for the right of women patients to have medical practitioners of their own sex. Two very influential men, Lord Hobart, the Governor of Madras, and Dr Balfour, the Surgeon General, backed her cause, which was also facilitated by the Indian Government's sympathy for the seemingly avoidable plight of women in childbirth. Their efforts led to the establishment of the Madras Medical College.⁶⁸ Scharlieb later recalled that

the Government of the day was deeply impressed by the loss of life and misery caused by the absence of medical aid for the high caste and gosha women, and on being memorialized they recorded their intention to admit women to existing classes at the medical college.⁶⁹

In 1878, Scharlieb returned to England because the Indian climate did not suit her, and because she wished to further her studies. An indication of her diligence and determination, common in the first generation medical women, was displayed on her journey home when, with three children in tow, she not only revised the requisite subjects for the London University matriculation exam, but she also "studied mathematics

⁶⁷ During an audience with Queen Victoria in 1883, the Queen told Scharlieb to send a message to her patients to say that "the Queen sympathizes with them, and ... [is] glad... that they should have medical women to help in then their time of need." See, Scharlieb, *BMJ*, p. 935.

⁶⁸ S. R. Collinson, 'Mary Ann Dacomb Scharlieb: A Medical life from Madras to Harley Street', *Journal of Medical Biography*, Vol. 7, no. 1, Feb.1999, pp. 25-31.

⁶⁹ Scharlieb, 'Medical Profession', p. 13.

with one of the engineers of the ship”.⁷⁰ Scharlieb arrived in England with letters of introduction to Florence Nightingale and Elizabeth Garrett Anderson, who was, by then, Dean of the newly founded London Medical School for Women, where Scharlieb enrolled to further pursue her medical studies. Scharlieb’s academic assiduousness was rewarded in her final MB exam when she won a gold medal and scholarship in obstetrics.

Jane Walker, who shared Scharlieb’s academic leanings, was born in Drewsbury, Yorkshire on 24 October 1859, the eldest of the eight children of John Walker, a blanket manufacturer and Mayor of Drewsbury.⁷¹ Her father influenced and encouraged her choice of a career in medicine.⁷² Following secondary education at Southport, she attended the LSMW, qualified as LRCPI and LM from Dublin in 1884 and LRCS Edinburgh in 1889. Since the possibility of obtaining a doctorate in medicine in the UK was closed to women at the time, she was forced to go overseas to complete her post-graduate education. She travelled to Brussels and qualified MD from Brussels University in 1890. One of the early suffragists, Walker strongly believed in the educational abilities of women and was an influential role model for the next generation.

Charlotte Louisa Ellaby’s entry into medicine was achieved through “the most indomitable pluck and perseverance”.⁷³ Following the advice of Elizabeth Garrett Anderson, Ellaby gained her work experience in India

⁷⁰ Anon, “Mary Scharlieb”, *DNB*, 1922-1930, pp. 749-751.

⁷¹ Walker, ‘Scharlieb’, p. 937.

⁷² Anon, ‘Dr. Jane Walker’, p. 108

⁷³ Anon, ‘Ellaby’, *BMJ*, p. 1335.

and specialised in ophthalmology. She later remarked that “it was not in the power of every one to be a genius or to make a mark in the world, but it did rest with each one to make, as Jean Paul Richter said, ‘as much of ourselves as could be made out of the stuff’”.⁷⁴ When Ellaby addressed the students at the LSMW in 1895, she advised them in their acquisition of knowledge “to be bold, be bold, and everywhere be bold”.⁷⁵ Harley Street women such as Mary Scharlieb, Jane Walker, May Thorne and Florence Boyd were keen supporters and promoters of women in the profession. Scharlieb called for the dissemination of information so women could be given the opportunity to enter the profession.⁷⁶ Walker, in her address to students at the London (Royal Free Hospital) School of Medicine for Women, urged women to “be loyal to one another”.⁷⁷

This pursuit of medicine by the first generation Harley Street women testifies that their motivation to enter medicine cannot be simply categorised as “purely missionary zeal” or “sympathy for human suffering”. With increasing prosperity amongst the middle classes by the 1870s, woman’s increased leisure time was seen as a reflection of their male provider’s success: a symbol of his conspicuous consumption.⁷⁸ An analysis of these women’s careers showed that the philanthropic aspect of medicine was not just an end in itself, but a means to a higher end: this group not

⁷⁴ Anon, *Morning Post*, Oct. 2, 1895, RFHSM PC, Book 3, p. 59.

⁷⁵ Anon, *The Times*, Oct. 2 1895, RFHSM PC, Book 3, p. 59.

⁷⁶ Anon, *The Queen*, Dec. 15 1888, RFHSM PC, Book 3, p. 34.

⁷⁷ Anon, *The Times*, 2. Oct. 1929, RFHSM PC, Book 7, part 1, p. 165,

⁷⁸ For a discussion of the oppression of women in the nineteenth century and the emergence of a feminist response see, Sheila Rowbotham, *Hidden from History*, (London, 1977), *passim*.

only gained intellectual satisfaction, but they broke from the restrictions of the role of “passive female” ascribed to middle class women in Victorian Britain.⁷⁹ According to the *Lancet*, women who pursued a career in medicine could only be “drawn from the same rank as male physicians’, that is, the middle class”.⁸⁰ The first generation challenged Victorian notions of female capacity that middle class woman should not work, because “their sensibility and delicacy would not permit it.”⁸¹

Connections and Relationships

Entry to Harley Street was easier for the second generation, as they all knew at least one other female medical practitioner in practice in Harley Street before they arrived. Thirteen (54%) shared a practice with a female incumbent and a further seven (29%) moved into practices in Harley Street with either their husband or brother.⁸² Eleanor Davies-Colley had already spent much of her childhood with her father, John Neville Davies-Colley, an eminent surgeon who lived in Harley Street.⁸³ May Thorne set up practice at her mother Isabel Thorne’s address, number 148 Harley Street, and Dyddgu Hamilton moved into number 121 with Ann Piercy and Willmott Evans.⁸⁴ The remaining two women (9%) met as students at the LSMW in

⁷⁹ May, *Britain*, for a discussion of gender roles see Chapter on ‘Women in Nineteenth Century’, pp. 284-305.

⁸⁰ *Ibid.*, p. 300

⁸¹ *Ibid.*

⁸² For example in 1912, Eleanor Davies-Colley moved into the practice established by Mary Chadburn in 1899 and in 1907 De Steiger, Stoney and Taylor moved into a practice established by Ellaby in the previous year.

⁸³ John Neville Davies-Colley was in Harley Street from 1877 to 1901. He was also a student at the LSMW in 1897 with Garrett Anderson.

⁸⁴ Ann Piercy Evans qualified but gave up medicine on her marriage to Willmott Evans in 1895.

1891.⁸⁵ Other acquaintances arose through membership of such medical societies as the Association of Registered Medical Women and the BMA. Many women also established relations with the other Harley Street women in their working environment.⁸⁶

The majority of these women would have been able to call on the support of other practitioners in the Street and would have had contact with them through their work and in their membership of professional societies. There was a considerable amount of professional admiration amongst colleagues, which was also found amongst the male cohort. Maud Chadburn thought that, “as a surgeon, Miss Davies-Colley was very observant, of clear logical mind, of keen intelligence, skilful, experienced”.⁸⁷ Chadburn found in Emily Flemming, someone who “had a wide knowledge of medicine, a scientific mind and absolute honesty”.⁸⁸ Agnes Savill, a fellow Harley Street medical practitioner, praised Florence Stoney’s pioneering work in electrotherapeutics and X-ray. She described her as a “helpful, generous colleague, reliable, thorough, persevering, accurate in all she undertook”.⁸⁹ Scharlieb held Florence Boyd’s “many years’ good work as a surgeon at the New

⁸⁵ Gordon and Boyd studied at the LSMW in the late 1880’s. Boyd was also a close friend of Mary Scharlieb; they met around 1880 when they were students at the LSMW. Scharlieb, *Reminiscences*, pp. 140–141. Louisa Garrett Anderson and Ethel Vaughan-Sawyer were also fellow students at the LSMW from 1891.

⁸⁶ For example, Mary Scharlieb worked with Mrs Stanley Boyd, Jane Walker and Ethel Vaughan Sawyer at The New Hospital for women. Davies-Colley and Chadburn set up the South London Hospital for women together.

⁸⁷ Maud Chadburn, ‘Eleanor Davies-Colley’, Archives of the MWF, Wellcome, SA/MWF/B.8-11.

⁸⁸ Maud Chadburn, ‘Emily Flemming’, Archives of the MWF, Wellcome, SA/MWF, Box 13/B.2/10. Jan 1939 - Oct 1940.

⁸⁹ Agnes Savill, ‘Florence Stoney’, obituary notices, Archives of the Royal Free.

Hospital", in esteem and regarded Jane Walker as "a highly valued colleague [who] accomplished much hard and valuable work".⁹⁰

Motivation of the Second Generation

The motives for forging a career in medicine were different for the second generation of women than they were for the first generation.⁹¹ Whilst personal experiences were still important, medicine was seen as a more acceptable career option for these women than it was for their predecessors. Some were encouraged to pursue medicine as a career by a parent, particularly those who came from a medical background. Elizabeth Garrett Anderson saw her daughter, Louisa, leave for France during the First World War to become the chief surgeon of the first women's unit there. Shortly after her daughter left, Elizabeth remarked that if the unit succeeded "they would expedite the women's cause by thirty years".⁹² May Thorne, encouraged by her mother Isabel Thorne, went into medicine at the relatively mature age of 30 because she wanted to help her mother at the LSMW.⁹³

Like Jane Walker, who received her father's encouragement to pursue medicine, Florence Ada Stoney's father G. J. Stoney, ScD, FRS, Secretary of the Queen's University of Belfast, supported her choice of study. Stoney, in common with many of the women from the first generation, possessed a

⁹⁰ Scharlieb, *Reminiscences*, p. 141.

⁹¹ See Elston, 'Women Doctors', *passim*, for a detailed study of the different motives for the first and second generation.

⁹² Anon, 'Women at Work', *The Times*, April 29 1939, RFHSM PC, Book 8, part 1, p. 122.

⁹³ Anon, 'May Thorne', *BMJ*, Nov. 3 1951, p. 1094, the reason was not given in her obituary though presumably she wished to help her mother at the LSMW. Although May Thorne had a Harley Street practice from 1905, she did not return to it after the war. She followed her mother's footsteps and became secretary of the LSMW.

sharp intellect. She was described as someone “blessed with exceptional ability and intellect” and who “aimed high and strove for excellence”.⁹⁴ An obituary notice in *The Vote* described her “iron will and undaunted courage”.⁹⁵ Stoney received the Mackay prize as top student in her year group at the London School of Medicine and won “class prizes or honour certificates in every subject taken”.⁹⁶ Other distinguished scholars from Harley Street include Ethel Vaughan-Sawyer, Emily Flemming and Florence Boyd, all of whom won academic prizes. Although not all Harley Street medical women were exceptional students, the majority (58 per cent) of the cohort had qualified MD by the time of their arrival in the Street.⁹⁷ The entire first generation and half of those in the second generation of Harley Street were MDs by the time they left the Street. Whilst, Elston calculated that 35 out of her sample of 55 of the first generation had MD degrees.⁹⁸ The educational advancement of four of the Harley Street women of the second generation who did not obtain MDs may have been impeded due to the onset of the First World War.⁹⁹

⁹⁴ Dr Helen Chambers, ‘Florence Stoney’, ‘Obituary Notices’, archives of the Royal Free.

⁹⁵ Anon, *The Vote*, Oct. 28 1932, in ‘Some Extracts from Various Obituary Notices’, archives of the Royal Free.

⁹⁶ Anon, *The Magazine of the London (Royal Free Hospital School of Medicine for Women)*, Nov. 1932.

⁹⁷ Mary Scharlieb, Boyd, Chadburn, Walker, Anderson, Thorne, Ellaby, De Steiger, Stoney, Savill, Vaughan-Sawyer, Flemming, Davies-Colley, Mecedry.

⁹⁸ Elston, ‘Women Doctors’, p. 181.

⁹⁹ Three women (13%) arrived in Harley Street in the first year of World War One. This may have been a reason for not continuing their studies. Katherine Harman ceased to practice at the outset of war.

Background and Medical Education

As was typical of the Victorian medical profession, two thirds of the cohort had middle class parents.¹⁰⁰ Five of their fathers were in the legal profession, three were church ministers, three were businessmen, two were members of the medical profession, one was a tea merchant and one was an architect. In addition, Mary Ethel Sim Scharlieb, Louisa Garret Anderson and May Thorne's mothers had been part of the first generation of medical graduates. Whilst it has not been possible to trace the secondary education of the entire cohort, approximately a third attended their local high school.¹⁰¹ In addition, a minority, ($n = 3$) received part of their education at home, all of whom were daughters of a medical practitioner.¹⁰²

The majority of this female cohort received their training at the LSMW and proceeded to take a MB or BS degrees at London University.¹⁰³ Although the Royal College of Surgeons in Ireland was the first Royal College to admit women to its Fellowship in 1896, the RCS in England did not admit women to both the membership and the fellowship until 1911, and women could not take part in the administration or running of the

¹⁰⁰ Anon, *The Medical Women's Federation Quarterly Review*, Jan, 1939- Oct 1940, pp. 40-41, information also obtained from obituaries and *Who's Who*.

¹⁰¹ For example, K. Harman attended Egbaston High School; A. G. Savill attended Dundee High School. E. Davies-Colley attended Baker Street High School and E. Mecredy attended Leeds High School.

¹⁰² M. Thorne and F.A. Stoney were educated 'privately'. Mary Scharlieb received her preliminary education at home and then went on to St Leonard's School. Application forms, Royal Free archives.

¹⁰³ St George's, the London, St Mary's, Charing Cross and Westminster, which had admitted women during the war, later excluded them. See Carol Dyhouse, 'Driving Ambitions: Women in Pursuit of Medical Education, 1890-1939', *Women's History Review*, Vol. 7, No. 3, 1998, p. 321. p. 332.

College.¹⁰⁴ Though the RCP admitted women as licentiates and members in 1909, women were still ineligible for the fellowship or the government and management of the College. Following a motion by Dr John Fawcett and seconded by the Harley Street physician, Dr Edward Farquhar Buzzard, a College by-law was amended in order to allow women entry to the fellowship in 1925, but it was not until 1934 that the first woman fellow was elected.

Unlike a number of the male Harley Street practitioners who qualified BA or MA, only Agnes Forbes Savill acquired an Arts degree when she received her MA from St Andrews in 1895. She gained her medical degree MB, ChB (1898) at Glasgow University where a degree in Arts (or a preliminary examination) was a prerequisite.¹⁰⁵ Before a student could embark on a degree course at the London University or an Irish University, they needed to matriculate. Of the 16 women who could be traced, most prepared for their matriculation at Queen's College, Harley Street.

As shown in Table 7.3 Appendix F, the LSMW provided the medical education for the majority of the Harley Street women. The LSMW was the only Medical School in London where women were able to gain pre-clinical teaching. It had 133 students by 1909.¹⁰⁶ As a short-term measure designed to meet the exigency of the First World War, seven London medical schools

¹⁰⁴ Cooke, *RCP*, p. 976.

¹⁰⁵ Charles Bell Keetley, edited by the author and Robert Wharry, *The Students and Junior Guide to the Medical Profession*, (London, 1885, 2nd edition), pp. 118-119.

¹⁰⁶ As Elston in 'Women Doctors', p. 175, has pointed out, up to the First World War most of the women medical students attended all female medical schools such as the LSMW.

admitted women to their clinical courses for the first time.¹⁰⁷ However, by 1928, all these had closed their doors to new female students.

Hospital Training and Practice

Until 1914, medical appointments for women were scarce. Before this time the only positions available were clinical assistant, house surgeon or assistant medical officer in hospitals run by women, in small specialist hospitals like St John's Skin Hospital or hospitals for women or children such as the Children's Hospital, Shadwell or Clapham Maternity Hospital. It was not until the Great War that London general hospitals opened their doors to women.

Women benefited from the burgeoning of special hospitals that began in the mid-nineteenth century, which included hospitals for the diseases of women and children, eye hospitals and skin hospitals.¹⁰⁸ The majority of the cohort of the second generation received their training from the New Hospital for Women and The Royal Free Hospital. Special hospitals such as the Throat Hospital, Golden Square, the skin hospitals of St John's and Blackfriars and infirmaries such as Camberwell remained important in establishing women's careers.

In July 1866, Elizabeth Garrett Anderson established St Mary's Dispensary in Seymour Place, St Marylebone, with the aim of providing a

¹⁰⁷ These were St Mary's, Charing Cross, St George's, Westminster, London and King's College. In 1916, St Mary's Hospital Medical School was one of the first to admit women medical students, see, Garner, 'Great Experiment', p. 71

¹⁰⁸ Lindsay Granshaw, 'Fame and Fortune by Means of Bricks and Mortar: the Medical Profession and Specialist Hospitals in Britain, 1800-1948' in Lindsay Granshaw and Roy Porter, eds., *The Hospital in History* (London, 1990), p. 206.

place where women could obtain medical and surgical treatment from female medical practitioners. The dispensary proved very popular and in 1872 when extra beds were added to accommodate the increase in patients, the dispensary changed its name to The New Hospital for Women (NHW). Two years later the hospital moved to larger premises on Marylebone Road, and in 1917, the hospital expanded further and was re-established on the Euston Road.¹⁰⁹ Four of the cohort in the second generation took positions as surgical and/or medical clinical assistants at the hospital. A further five held positions at the RFH and four held junior positions at both hospitals.

Thus, it may be seen that a practice in Harley Street enhanced the opportunities for hospital positions for these women. For the majority, (two thirds of the cohort), their time in Harley Street represented increasing advancement in their profession.¹¹⁰ There were, however, a couple of women such as Lilian Chesney and Charlotte Ellaby, who were well advanced in their careers before they moved to the Street.¹¹¹ Despite Mary Ann Elston's argument that only a "minute number" of the first generation of women medical practitioners in Britain managed to procure appointments as a clinical assistant or resident medical officer, the majority of the Harley Street female cohort managed to do so.¹¹² Several, such as Scharlieb,

¹⁰⁹ Louisa Garrett Anderson, *Anderson*, pp. 241-250.

¹¹⁰ Scharlieb became a consultant physician at the RFH and consultant surgeon at the South London Hospital for Women. Boyd became a senior surgeon at the NHW, Flemming became a consultant physician at the NHW and Vaughan-Sawyer became a consultant gynaecologist at the RFH.

¹¹¹ Ellaby was a consultant ophthalmic surgeon, NHW and Chesney assistant medical superintendent at Walker's sanatorium.

¹¹² Elston, 'Women Doctors', pp. 210 and 232-233.

Vaughan-Sawyer, Stoney, Ellaby, Davies-Colley, Chadburn, Thorne and Flemming were consultants at the NHW or the RFH.

A number of Harley Street women played key roles in significantly advancing the opportunities for women by the creation of new hospitals. Maud Mary Chadburn and Eleanor Davies-Colley established the South London Hospital for Women in 1912, which was staffed entirely by women and eventually had 260 beds. One of their chief aims was to provide women with an opportunity to hold a senior position in a large hospital. Chadburn became the hospital's senior surgeon and Davies-Colley held the position of surgeon. When the hospital closed in 1985, after being absorbed by St George's Hospital, a ward was named after Chadburn, because she was a "pioneer [who] during her professional career, was one of the most prominent women in medicine".¹¹³ When Chadburn set up the Marie Curie Hospital in Hampstead for women suffering from cancer, it "was the only one of its kind" when it opened with 17 women members of staff.¹¹⁴ In 1901, Walker established the East Anglian Sanatorium for the treatment of tuberculosis. By 1912, Louisa Garrett Anderson, together with Flora Murray (not a Harley Street practitioner), had founded the Women's Hospital for Children in the Harrow Road. These institutions were a crucial training ground for women at a time of restricted options.

¹¹³ Terry Gould & David Uttley, *St George's Hospital and the Origin of its Ward Names* (London, 1997), p. 54.

¹¹⁴ Anon, 'A Hospital run by Women', *Daily Dispatch*, Manchester, 5. Feb. 1930, RFHSM PC, Book 7, part 1, p. 183.

Type of Practice by Harley Street Women

Though it was rare for the first generation of women practitioners throughout Britain to become specialists, all of the first generation Harley Street women specialised in a particular area.¹¹⁵ Jane Walker, an expert in pulmonary diseases introduced the first open-air treatment for tuberculosis, became the first female clinical assistant to the East London Hospital for Children in 1886 and six years after her appointment, she set up a small treatment centre for TB in Norfolk.¹¹⁶ Following its success, she established a sanatorium at Nayland, Suffolk in 1901 and became its medical superintendent. Walker opened a sanatorium for poor patients in 1904 and a children's sanatorium was added in 1912. Patients usually consulted her at her Harley Street practice before being admitted to the sanatorium.¹¹⁷ By 1917, approximately 300 patients, including men, women and children, were being cared for at her sanatoria.¹¹⁸ Another first generation Harley Street woman, Charlotte Ellaby, specialised in ophthalmology.

When Florence Stanley Boyd was asked by a reporter from the *New York Herald* in 1890, whether women in private practice specialised in gynaecology and obstetrics in England, because this was generally considered standard practice in the United States, Boyd replied "no".¹¹⁹ She went on to say that although their work "lies naturally among women and

¹¹⁵ See Anna and Michael Smith *Dr Jane Walker and her Hospital*, (Suffolk, no date, but probably 20th Century), p. postscript.

¹¹⁶ John Pickstone, (ed.), *Medical Innovations in Historical Perspective*, (London, 1992), pp. 48- 53. During the Nineteenth Century, consumption was the main cause of mortality in Britain.

¹¹⁷ Smith, *Walker*, p. 11.

¹¹⁸ *Ibid.*, p. postscript.

¹¹⁹ Mrs Boyd moved to Harley Street in the following year, i.e. 1891.

children", they also took general medical cases. Nevertheless, Mary Scharlieb recalled in her *Reminiscences* that:

we pioneer medical women were never able to be what is called pure physicians or pure surgeons. We had of necessity in those early days to be willing to give advice to women as to their health, whether from the medical, surgical or obstetric point of view.¹²⁰

Though Scharlieb managed to gain surgical experience in obstetrics and gynaecology whilst working in Madras, this was not standard practice because this path was unavailable to her female contemporaries practising in Britain. Her valuable experience in Madras opened the doors to consultancy when she was appointed gynaecological surgeon at the Royal Free in 1902, and thus became the first woman to hold a position of this kind in Britain. Her role was crucial to the next generation of women surgeons, as it "brought about a major development in the surgical work, especially gynaecological surgery, at the NHW".¹²¹

Approximately half of the second-generation of Harley Street women decided to concentrate their medical career in one area. The most popular specialities were obstetrics and gynaecology, practised by four women in this group. Maud Chadburn, for example, "had a large and successful practice in general surgery and gynaecology" at a time when "women surgeons usually did not separate these two specialities".¹²² Others such as Agnes Savill, Kate Addison, Mary Gordon and Adele De Steiger practised in the fields of

¹²⁰ Scharlieb, *Reminiscences*, p. 141.

¹²¹ Elston, 'Women Doctors', p. 218.

¹²² Anon, *Lancet*, May 4, 1957, RFHSM PC, Book 8, part 2, p. 247.

electro-therapeutics, dermatology, inebriety and the treatment of insanity respectively.¹²³

Teachers and Demonstrators

Most female Harley Street practitioners attended the LSMW, which “had dominated the early output of female graduates in Britain”, and had provided them with an opportunity to gain valuable teaching experience at a time when few positions were open to women in medicine.¹²⁴ Emily Elizabeth Flemming became the school’s first demonstrator of anatomy in 1892. Eight more of the cohort held lectureships at the medical school: four were demonstrators of anatomy, two lectured on gynaecology, one in medical jurisprudence and the last in ophthalmic surgery.¹²⁵ In addition, Emily Mary Mecredy and Jane Hawthorne were lecturers and examiners for the London County Council.¹²⁶ Given her previous teaching experience, Mary Scharlieb stressed the importance of gaining teaching experience for one’s career development when she addressed new students at the LSMW:

in February 1888 I was definitely appointed Clinical Assistant to Mrs. Garrett Anderson at the New Hospital, so now I was Lecturer to my School

¹²³ Chadburn was a senior obstetrician at the New Hospital for Women and consultant at the South London Hospital for Women. Davies-Colley was consultant obstetrician at the Elizabeth Garret Anderson Hospital. In 1908, Vaughan-Sawyer took over from Scharlieb as consultant gynaecologist and obstetrician at the RFH. Mecredy was a consultant gynaecologist at the RFH. The other specialist areas were: - Stoney in radiology, Savill in electro-therapeutics and skin diseases, Addison in dermatology, Gordon in the treatment of inebriates (she became assistant inspector of the State and Certified Inebriate Reformatories), Adele De Steiger in the treatment of insanity (at Essex Co. Asylum). Ellaby was consultant ophthalmologist at the NHW. No information was available for six of the cohort.

¹²⁴ Anne Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford, 1999), p. 158.

¹²⁵ Mrs Isabel Thorne, *Sketch and the Foundation of the London School of Medicine for Women* (London, 1915), p. 37.

¹²⁶ Mecredy was appointed in 1912.

and an Officer at the Hospital, two objects of ambition with every junior practitioner.¹²⁷

Scharlieb became the first woman to lecture in medical jurisprudence at the LSMW and went on to build an impressive career as a demonstrator and lecturer in gynaecology.¹²⁸ In 1889, she was appointed as lecturer in the diseases of women and soon after took up the chair of Midwifery. Ethel Vaughan succeeded Scharlieb in the chair of gynaecology in 1910 and later lectured in gynaecology at the University of London.¹²⁹

Professional Advancement: Membership of Medical Societies

The majority of Harley Street women attended one or all of the following societies: the Association of Registered Medical Women (hereafter referred to as the Association) and its successor, The Medical Women's Federation (MWF), the British Medical Association (BMA) and the Royal Society of Medicine. The Association and the MWF had the greatest affiliation from the female cohort. The MWF consolidated a hitherto loosely related set of local medical associations, of which the Medical Women's Association was one. This first association began in 1879 under the supervision of Elizabeth Blackwell and Elizabeth Garrett Anderson. The association aimed to protect and promote the interests of female medical practitioners. Meetings were held on the first Tuesday of every month at the Medical Institute, New Hospital for Women on the Euston Road, "for the shewing of cases and

¹²⁷ Scharlieb, *Reminiscences*, p. 146.

¹²⁸ *Ibid.*, pp. 147-167, Scharlieb was appointed demonstrator of practical gynaecology to the New Hospital in 1888, lecturer on physiology to the Queen's Jubilee nurses in 1888. By 1902, she was an examiner to women candidates for the Civil Service.

¹²⁹ Vaughan-Sawyer had been a tutor in gynaecology at the Royal Free Hospital from 1902-08.

specimens, the reading of papers, the discussion of medical subjects, and of other matters that may arise, touching the interests of women".¹³⁰ See Tables 7. 5 and 7. 6, Appendix F.

Elizabeth Garrett Anderson was the first medical woman to be elected as a member of the Metropolitan Counties Branch of the BMA in 1873, a year before the association was incorporated. Since the BMA had not excluded women in their articles, membership was open to anyone on the *Medical Register*. The majority of male practitioners, however, opposed the addition of women. When Garrett Anderson became the first woman President of the BMA's East Anglian branch in 1897, counsel was consulted to determine whether she could legally become a member.¹³¹ Though eligible for membership after the society was incorporated in 1874, a resolution was passed that would exclude women. This decision was supported by the Bath branch of the society in 1878 and it was not until 1892 that the Nottingham branch removed this barrier and women were then free to join the BMA.

By 1914, the list of members of the Association of Registered Medical Women exceeded 225, the catchment area being predominately London. By 1929, the list had expanded to 1,200.¹³² Membership of the organisation was open to all registered women medical practitioners of the United Kingdom. Ten independent societies for women merged in 1917 to form The Medical Women's Federation, which was founded by two Harley Street women, Jane

¹³⁰ 'Constitution' archives of the MWF at the Wellcome, MWF/ C. 7L.

¹³¹ Hall, 'Medical Women's Federation', pp. 91-94.

¹³² Anon, 'Constitution' and the 'List of Members of the Association of Registered Medical Women', the archives at the Wellcome, MWF/ C. 7L. Of the total, in 1913-14, 14 were listed as practising in Harley Street.

Walker and Eleanor Davies-Colley. Walker was also its first President (1917-1920) and later she held the posts of honorary treasurer and honorary secretary.¹³³ The *Lancet* reported that “it was in large measure due to Dr. Walker that the Federation emerged, and has expanded on such sound lines”.¹³⁴ In 1919, this organisation became affiliated with The American Medical Women’s Association, established in 1916, to form the first International Women’s Medical Association. The aim of the society was “to provide [a] means of communication between all medical women, to promote their general interest and to further friendship and understanding between the medical women of the world”.¹³⁵

The amalgamation of these separate national medical societies gave it some political power. Dr Mary D. Sturge affirmed that the Federation operated as “a lever for obtaining justice” by promoting equal pay in the public sector.¹³⁶ The aim of the Medical Women’s Federation was to:

- (1) safeguard and promote the professional interests of medical women. (2) To enable them to speak as a body and so to exert a greater influence on public policy in regard to those matters, such as health administration, in which they are directly concerned.¹³⁷

The Federation’s focus was predominately, on the rights and professional issues of medical women. They addressed representation on the BMA committees that dealt with the Insurance Act, The Ministry of Health, Maternity and Child Welfare, and they participated in various

¹³³ Anon, ‘Jane Walker’, *BMJ*, Nov. 26, 1938, p.1120 and Anon, *BMJ*, Oct. 22, 1932.

¹³⁴ Anon, ‘Jane Walker’, *Lancet*, Nov. 26, 1938, pp. 1259-61.

¹³⁵ Janet Aitken, ‘The Medical Women’s International Association’, *Journal of the MWF*, Jubilee, 1917-1967, p. 79.

¹³⁶ Dr. Mary D. Sturge, ‘The Medical Women’s Federation-its Work and Aims’, *MWF, Quarterly News-Letter*, Dec. 1921, pp. 17-25.

¹³⁷ *Medical Directory*, Vol. 1925, p. 412.

Parliamentary sub-Committees.¹³⁸ The Federation discussed various topics including nutrition, venereal disease, penal reform and lunacy. By the time Walker died on 17th November 1938, the Federation had campaigned successfully for a female representative to the GMC.¹³⁹

Following the formation of the Royal Society of Medicine, London in 1907, women were admitted as members of the sections of the society only, but not as Fellows. Although Mary Scharlieb was a member of the Council of the Obstetrics and Gynaecological Section from 1907, she was not permitted to participate in the election of officers or in the running of the society. Other societies, such as the Society of Anaesthetists, encouraged female members: they would only agree to the proposed amalgamation scheme of the RSM if women were admitted as Fellows.¹⁴⁰ Five years later, with the abrogation of the rules relating to the exclusion of women as Fellows, Jane Walker was elected as the first female Fellow at the RSM.¹⁴¹ She was also the first woman to sit on the Council of the RSM, a position she held from 1917-1929.¹⁴² Nine women in Harley Street who subscribed to the RSM became Fellows. Although the *Medical Directory* records only 48% ($n = 11$) of the group being members of the RSM, at least 58% ($n = 14$), of the

¹³⁸ The Sickness Insurance Committee approved the appointment of women to their advisory committee early in 1912. See Wellcome, letter from the BMA, Feb. 3. 1912, MWF archives, section IV (1), C.77.

¹³⁹ See Jean M. Scott, 'Women and the GMC: the struggle for representation', *Journal of the Royal Society of Medicine*, Vol. 81, No. 1, Mar. 1988, pp. 164-166 and Lesley A. Hall, '80 years of the Medical Women's Federation', *Medical Woman*, Vol. 16, no. 2, Summer 1997, pp. 6-9.

¹⁴⁰ Anon, *The Royal Society of Medicine*, (London, 1914), p. 144.

¹⁴¹ See M. Davidson, *The Royal Society of Medicine*, (London, 1955), pp. 41 & 56.

¹⁴² Smith, *Walker*, p. 48.

women chose not to return details of their membership to the *Medical Directory*.

The majority of Harley Street women, including Walker, Boyd, Stoney, Chadburn and Savill, were active participators in medical societies.¹⁴³ Boyd and Thorne were both Presidents of the Association of Registered Women and three of the cohort were Vice-Presidents. Stoney was a founder and President of the Wessex branch of the British Institute of Radiology. Thus, the majority of Harley Street women held a senior position within the respected and well-known medical associations, thus confirming the cohort's prominence within the profession.

Professional Advancement: Publications

Publication was an important form of self-promotion within the medical career of the female cohort, as it was for their male counterparts. Just over half of the female cohort had their work published in a scientific journal or medical reference book. Several of these women ($n = 8$) published in specialist journals, such as the *British Journal of Inebriety*, *Journal of Mental Science* or *Journal of Physiology*. Others, including Scharlieb,

¹⁴³ Scharlieb often gave lectures and read scientific papers at the Association of Registered Medical Women; she was also an active member of the Obstetric Society and the Royal Society of Medicine, Anon, *Lancet*, Nov. 29, 1930, p. 1212. Stoney read a paper on goitre in 1912 at the BMA. She was also a founder and President of the Wessex Branch of the British Institute of Radiology. 'Ada Stoney', Obituary notices, Archives of the Royal Free. Boyd was Vice-President and Treasurer of the Association of Registered Women and Secretary of the Royal Society of Medicine. See Anon, *The Daily Telegraph*, 28 Oct, 1910, RFHSM PC, Book 4, p. 27. Chadburn was President of the MWF 1926-7. Anon, *BMJ*, 4 May 1957, RFHSM PC, Book 8, part 2, p. 247. Savill was Vice-President of the electro-therapeutic section of the Royal Society of Medicine. Dr Violet Kelynack who resided in Harley Street but did not practice was secretary of the British Medical Federation for 20 years, Anon, *Medical Woman's Journal*, 47, Nov. 1940, pp. 341-342. The cohort also included a Fellow of the Pathological Society, one Fellow from the Association of Surgeons of Great Britain.

Garrett Anderson, Boyd, Thorne, Stoney and Savill contributed articles to the *BMJ* or the *Lancet*. The most prolific of the group, Mary Scharlieb, was concerned with issues arising out of nineteenth century debates on racial degeneration and social purity. She also sat on the Royal Commission on Venereal Diseases (1913-16). An advocate of state support for women who produced healthy children, she published several books and pamphlets on eugenics, and the importance of the mother's role in improving the next generation; this material was specifically aimed at women. In *The Welfare of the Expectant Mother*, Scharlieb stressed that heredity and environment were the two factors, which determine human destiny:

the father's share in the endowment of his child must not be minimised nor overlooked; but probably the most hopeful field for both individual and national endeavour is the care and cultivation of the expectant mother.¹⁴⁴

Most of her published work dealt with similar issues.¹⁴⁵ Apart from Scharlieb, other women including Walker, Gordon and Savill, published books.¹⁴⁶ Walker's professional interests were wide ranging and this was reflected in her speeches and writings; apart from tuberculosis, she was also concerned with diseases of women and children, the education of mothers, infant mortality, the housing problem, nutrition, and the general improvement of social and economic conditions in the country.¹⁴⁷ Savill also wrote on an array of medical subjects from eczema to the use of electricity in

¹⁴⁴ Mary Scharlieb, *The Welfare of the Expectant Mother*, (London, 1919), pp. 1-2.

¹⁴⁵ Scharlieb's other publications are listed in Appendix E. She also contributed articles to the *Lancet* and *Queen* magazine.

¹⁴⁶ Gordon's publications are in Appendix E. She had been an Inspector of Prisons for thirteen years.

¹⁴⁷ Anon, 'Jane Walker', *Lancet*, pp. 1259-61.

the treatment of women's diseases.¹⁴⁸ For some women, such as Mary Chadburn, publication was not necessarily considered a prerequisite to success. Despite her distinction as a surgeon, "she was not a public figure, and she did not publish reports of her work".¹⁴⁹

Social Life and Interests

Consideration was given to the female cohort's membership of social clubs. Evidence of membership was not always easy to ascertain because the majority of women did not list their club membership.¹⁵⁰ Few of the women had entries in the *DNB* or *Who's Who* where social interests might have been obtained. There may be a number of reasons for this: the most important was perhaps that it was uncommon for a Victorian woman to become a member of a social club. According to the economic and social historian, Peter Clark:

female activity, though increasing by the 1780s, was always marginal; indeed, as we have argued, the absence of women was one of the essential, almost defining features of British clubs and societies in their formative period. Even into the Victorian era, despite their growing role in fund-raising for public subscription associations, women had a secondary position.¹⁵¹

For the cohort, membership of medical societies was the more usual method of interaction with their female peers. In early Victorian England, middle and upper class women were conventionally excluded from social

¹⁴⁸ Savill's publications are in Appendix E.

¹⁴⁹ Anon, 'Mary Chadburn', *Lancet*, May 4, 1957, p. 939.

¹⁵⁰ There were a couple of exceptions: Agnes Forbes Savill listed her membership of 'Sesame' under social clubs in *Who's Who*. Stoney was a member of the Lyceum. Some recorded their membership of political groups or parties. Louisa Garrett Anderson became active in the suffrage movement, becoming Vice-President of the United Suffragists in 1914. Jane Walker was an active member of the Labour party and Mary Chadburn a member of the International Women's Franchise.

¹⁵¹ Peter Clark, *British Clubs and Societies 1580-1800: the Origins of an Associated World* (Oxford, 2000), p. 483.

clubs and this situation did not change until after the First World War.¹⁵² However, these women found acceptable forms of social interaction through charity and community services.¹⁵³

Harley Street women were able to entertain at home since their houses were large and the reception rooms lent themselves to the necessary art of entertaining. Indeed having guests for drinks or dinner was regarded as, “an important and integral part of consulting practice” for both the female and male cohort.¹⁵⁴ The women who enjoyed this form of social intercourse included Dr Jane Walker, a committed Labour supporter whose salon at her house in Harley Street was legendary in London intellectual society. Her guests included the suffragette, Dame Millicent Fawcett (1847-1929), the Labour Prime Minister, Ramsey MacDonald (1866-1937), whose family were Dr. Walker’s patients, and William Temple (1881-1944) who became Archbishop of Canterbury in 1942.¹⁵⁵ Those who knew her well referred to her as “Lady Jane”. Her educated pastimes encompassed a keen interest in literature, classical music and the collection of works of art.¹⁵⁶

In common with many of the upper class, Mary Scharlieb’s interest lay in foreign travel. She also admitted to two social aspirations: “to be

¹⁵² *Ibid.*, pp. 130-131 and 198-201. P. Clark and R. Houston, ‘Culture and Leisure’ in Peter Clark, (ed.), *The Cambridge Urban History of Britain, Vol. 11, 1540-1840*, (Cambridge, 2000), p. 588.

¹⁵³ Martha Vicinus, *Independent Women: Work and Community for Single Women, 1850-1920*, (London, 1985).

¹⁵⁴ R. Scott Stevenson, *Goodbye to Harley Street*, (London, 1954), p. 3.

¹⁵⁵ Smith, *Walker*, p. poscript, Ramsay Macdonald was Prime Minister from Jan-Nov 1924 and again between 1929-1935.

¹⁵⁶ Anon, ‘Jane Walker’, *Lancet*, Nov. 26, 1938, pp. 1259-1260.

presented at Court and to possess a diamond necklace.”¹⁵⁷ When her wishes were realised, Scharlieb acknowledged that she now had her “two vanities”.¹⁵⁸ Eleanor Davies-Colley and Louisa Garrett Anderson also enjoyed foreign travel and gardening, which was also a popular pastime for others in the group. Ethel Vaughan-Sawyer was perhaps the very antithesis of the quintessential Harley Street consultant for she was described as “unfashionably dressed”. Nor did she fit the stereotype of the middle class Victorian woman, as her range of stories was considered by some of her guests to have been “often unsuited to a drawing-room”.¹⁵⁹

Many members of the group such as May Thorne were described as good conversationalists or good speakers.¹⁶⁰ Thorne, who was described as “devoid of arrogance” went on to develop her broadcasting skills on the radio based on her knowledge of Florence Nightingale’s life and work. Thorne was Nightingale’s doctor during her last few years and typical of the group whose work left her little time for genteel hobbies. She worked tirelessly to raise funds for the Patients and Friends League, which she founded in 1902.¹⁶¹ As with other medical middle-class women, Thorne’s interests were practical rather than the more genteel pursuits of “walking, sewing and

¹⁵⁷ Anon, ‘Scharlieb’, *Lancet*, pp. 1211-1212.

¹⁵⁸ *Ibid.*

¹⁵⁹ Anon, ‘Ethel Vaughan-Sawyer’, RFHSM PC, Book 5, pp. 183-185.

¹⁶⁰ For example, Ethel Vaughan-Sawyer, *Ibid.*, Dr Jane Walker, did a considerable amount of public speaking especially at the Women’s Federation and the BMA. Thorne and Scharlieb were described as good speakers, see Thorne May Thorne, ‘Then and Now’, *The R.F.H. Magazine* No. 34, Dec. 1951, Vol. XIII, pp. 128-129 and Dame Mary Scharlieb, *The Bachelor Woman and her Problems* (London, no date), pp. 45-46.

¹⁶¹ The League was set up at the Royal Free Hospital to raise funds for the hospital.

knitting".¹⁶² In general, the interests and pastimes of these women could be regarded as unpretentious; they had little interest in activities that would have supported Victorian ideals of feminine refinement. These women, some of whom were formidable, focused on their professional interests as medical practitioners, and they were not confined by Victorian conventions.

Marriage and Motherhood or Bachelor Girl

In 1870, the *BMJ* claimed that women's entry into medicine would lead to an increase in celibacy for both sexes. They reasoned that the competition from female practitioners would result in fewer patients for their male colleagues. Men would, therefore, earn less and could not afford to marry; consequently, there would be more single women who would need financial support. The *BMJ* also claimed somewhat derisively that:

the lady-doctor is therefore, as we take it, unless she be consequently an advocate of celibacy, a traitress to her sex. She betrays their real interests to her own eccentric longing for the will-o'-the-wisp pleasures of independence.¹⁶³

Even as late as 1936, an article in *The Medical Woman's Journal* suggested that only women who had a "superior" intellect should pursue a career in medicine, if they also wished to have a husband and family. The study of medicine for a woman of "average" intelligence with a maternal yearning, Hulda Therlander maintained, would be pointless as, "she will marry and have a family, and either give up medicine entirely or use it as a hobby".¹⁶⁴

The first generation of qualified women medical practitioners who also

¹⁶² 'May Thorne', *The Medical Who's Who*, 1925, p. 645. For the interests and social lives of middle-class women see, Joan Perkins, *Victorian Women*, *passim*.

¹⁶³ Anon, 'lady doctor', *BMJ*, April 2, 1870, pp. 338-339.

¹⁶⁴ Hulda E. Therlander, 'Women for Internships', *The Medical Woman's Journal*, Vol. XLIII, Dec, 1936, Number 12, pp. 324-326.

embraced motherhood, such as Elizabeth Garrett Anderson, Isobel Thorne, and Mary Scharlieb, were not only highly intelligent, but they also managed successfully to juggle their domestic and professional duties.

In her book, *Straight Talks to Women*, Mary Scharlieb extolled the virtues of motherhood. She offered an alternative to those who could not or did not wish to become a biological mother; she suggested that they could opt to nurture their mothering instincts through charitable deeds. Thus, Scharlieb believed that:

motherhood is the very crown and perfection of a woman's nature and until the motherly instinct is awakened, whether by the fact of natural motherhood or by spiritual influences, her character and faculties fall short of their ideal and possible perfection.¹⁶⁵

She later argued that the practice of medicine was a fitting occupation in which a woman could satisfy her motherly instincts, and it was also a profession in which women were "well-suited" and "successful".¹⁶⁶ Furthermore, she thought that the risk of remaining single was an atrophying of the unused parts of a woman's mind and body normally associated with marriage and procreation, which could lead to a tendency to "over intellectualization".¹⁶⁷ For Scharlieb and several of the other women, such as Isabel Thorne and Elizabeth Garrett Anderson, motherhood and a career in medicine were perfectly compatible.¹⁶⁸

During their time in Harley Street, nine of the cohort married and six of these became mothers. In addition, Mary Chadburn, although unmarried,

¹⁶⁵ Mary Scharlieb, *Straight Talks to Women* (London, 1923), p. 3

¹⁶⁶ *Ibid.*, pp. 34-35.

¹⁶⁷ Scharlieb, *Bachelor Woman*, pp. 45-46.

¹⁶⁸ When Isabel Thorne studied medicine in the University of Edinburgh 1869-1874, she brought her four children aged from 14 months to 10 years of age with her. See May Thorne, 'Then and Now', *The R.F.H. Magazine* No. 34, Dec. 1951, Vol. XIII, pp. 128-130.

adopted three children.¹⁶⁹ Two of the women in the Harley Street second generation, Louisa Garrett Anderson and May Thorne, remained single. As May Thorne reflected when discussing her mother's family of four children, "many women might have thought this family [was] a considerable handicap to beginning an arduous education. Not so my brave mother".¹⁷⁰ Nevertheless, some of these women relinquished their practices when they married. Violet Kelynack and Ann Piercy Evans gave up practice in Harley Street when they married. Katherine Chamberlain who married the Harley Street practitioner, Nathaniel Bishop Harman, discontinued her practice at the start of the war. Victorian society expected married women to cease working and fulfil their obligations as wife and eventually mother; women who continued their careers after marriage were unusual. Those women who worked in the public sector, were forced to resign from their post on marriage which caused Walker to argue in the *Yorkshire Evening Post* in 1938 that: "many women will prefer to give up their posts on marriage: but in this land of freedom they should be allowed to make this decision themselves".¹⁷¹

The Great War

The onslaught of the war engendered new opportunities for women medical practitioners. Walker realised that the war represented a unique chance for women to capitalise on the increased demand for doctors and surgeons. Two years after the war began, the War Office called on female medical

¹⁶⁹ Anon, 'Mary Chadburn', *Lancet*, p. 939.

¹⁷⁰ Thorne, 'Then and Now', p. 130.

¹⁷¹ Anon, *Yorkshire Evening News*, Nov. 17, 1938, RFHSM PC, Book 8, part 1, p.108.

practitioners to join the medical corps. They did not, however, enjoy the same privileges as their male colleagues and were not entitled to the same basic pay, they did not receive the billeting or the ration allowance, nor did they receive the reduced rate of income tax given to the men. Unlike their male counterparts, female medical practitioners did not travel as "officers", but as "soldiers wives". The Women's Federation was inundated with complaints from women on this iniquity.¹⁷² Whilst the Federation was unsuccessful in changing the situation for medical women, they were a powerful lobby group and managed to have their grievances brought to the table in the House of Commons.¹⁷³

The Harley Street women who participated in the war effort took on leading roles: Lilian Chesney ran a hospital at Dobrudja, in the Serbian territory; Agnes Savill became chief of the electro-therapeutic department in the Scottish Women's Hospital at Royaumont, France and Louisa Garrett Anderson was not only appointed chief surgeon at the Military Hospital in Endell Street, London, but she and Flora Murray were the first women to run a military hospital in Britain.¹⁷⁴ Lord Knutsford later remarked, "these women have done the impossible": they had established themselves on the same terms as men in an area that had previously been closed to women.¹⁷⁵ In 1912, Anderson and Murray established the Harrow Road Hospital for

¹⁷² Jane Walker, 'Medical Women in the Army', *The Times*, July 4, 1918, RFHSM PC, Book 5, p. 121.

¹⁷³ Sturge, 'Women's Federation', pp. 17-25.

¹⁷⁴ Flora Murray, *Women as Army Surgeons*, (London, 1920), pp. vii-viii. Stoney was head of the medical staff and radiologist at a military hospital run by British women doctors in Antwerp in 1914. Lee, 'Stoney',

¹⁷⁵ L.M.B. *WMF Quarterly Review*, p. 41, Wellcome, Archives of the MWF, SA/MWF/B.2/12-13, Box 14.

women and children. Florence Stoney, who was also involved in the war effort, was awarded along with her female corps, the 1914 star from the Admiralty for their work in their military hospital in Antwerp.¹⁷⁶

Conclusion

The first women to arrive in Harley Street were a distinguished group of medical practitioners. They were exceptional amongst women who qualified in medicine in Britain during the period.¹⁷⁷ At a meeting of 200 “lady doctors” attending the International Congress of Medicine in 1913, Walker was described in the press as “a Harley-street physician who is one of the best-known of British lady doctors”.¹⁷⁸ Scharlieb, Chadburn and Davies-Colley were similarly well known in the profession and all of the cohort possessed the necessary determination to break into the élite male enclave of Harley Street at a time when women were generally considered intellectually inferior to men and were marginalized by society.¹⁷⁹

The majority of the cohort succeeded in building a large and lucrative practice. Chadburn, for example, who concentrated on general surgery and gynaecology, “ran two large nursing homes for her private practice”.¹⁸⁰ In his exposition on the Medical Profession in 1905, M. Foster Reaney realised that:

¹⁷⁶ ‘Florence Stoney’, *The Magazine of the London (Royal Free Hospital) School of Medicine for Women*, November 1932.

¹⁷⁷ Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, (Cambridge, 1994), p.294. In an examination of the first posts held by Edinburgh female graduates, 1902-04 Digby calculated that only 5% were in private practice.

¹⁷⁸ Anon, *Daily Sketch*, Aug. 11 1913, RFHSM PC, Book 4.

¹⁷⁹ Jane McDermid, ‘Women and Education’ in June Purvis, (ed.), *Women’s History: Britain, 1850-1945* (London, 1995), pp. 107-130.

¹⁸⁰ Anon, ‘Chadburn’, *Lancet*, p. 939.

it is only the few [women] who enter private practice; and these as far as one can see, obtain[ed] a fair share of success. Here, again, they have to be proof against the prejudices of the public, not always expressed silently; and unless they be enthusiasts they will soon return to easier paths.¹⁸¹

Digby argued that women “needed considerable determination to enter general practice single-handedly as a female GP”.¹⁸² The prerequisites to putting up one’s brass plate in Harley Street also involved a considerable amount of money and a degree of fortitude. As the *Sunday Chronicle* pointed out in 1908, Louisa Garrett Anderson had set up practice in the “fashionable and *expensive* London doctor-dom of Harley Street” (Italics mine).¹⁸³ Scharlieb gave the matter serious consideration before putting up her brass plate in the Street, as “the expense would be relatively enormous, but the professional gain seemed to outweigh economical considerations”.¹⁸⁴ The income from Scharlieb’s first six months of practice amounted to £200, which was a considerable amount, particularly as she had only just become established. Digby’s estimate, that the gross income for a medical practitioner in the first year of practice was £150 - £400 per annum, places Scharlieb at the upper end of the scale.¹⁸⁵ On the recommendation of Elizabeth Garrett Anderson, Scharlieb charged her patients a guinea for consultation during her first few years. By 1902, she had established a large and successful practice and as it flourished, she raised the fee to two

¹⁸¹ M. Foster Reaney, *The Medical Profession: The Carmichael Prize Essay for 1904*, (Dublin, 1905), p. 104.

¹⁸² Digby, *General Practice*, p. 166.

¹⁸³ Anon, *Sunday Chronicle*, 1908, RFHSM PC, Book 4, p. 20.

¹⁸⁴ Scharlieb, *Reminiscences*, p. 129. No data was available for the lease or premium paid by Scharlieb in 1888. When Jane Walker moved to Harley Street four years later she paid £80 p. a. for the lease. The premium was an additional £300. In 1914, the rent was increased to £100 p.a. and the premium to £400. “The book of terms”, archives of the Howard de Walden Estate. Rent and premiums varied considerably depending on the terms of the lease.

¹⁸⁵ Digby, *Medical Living*, p. 143.

guineas, which was the standard fee charged by her male colleagues in Harley Street.¹⁸⁶

There are various measures of eminence, and the conferral of an award or honour is one indicator. Three Harley Street women were rewarded with honours for their courage and medical skill during the Great War: Thorne and Stoney received OBEs and Garrett Anderson the CBE.¹⁸⁷ Scharlieb received an honorary LLD from the University of Edinburgh and was appointed CBE in 1917 and was created a Dame of the British Empire in 1926. Six years earlier she had been appointed one of the first female magistrates of the Juvenile Court.¹⁸⁸ Walker was given the Companion of Honour in 1931 in recognition of her "pioneer work" on tuberculosis and the University of Leeds presented her with an honorary LLD.¹⁸⁹ Chadburn was appointed CBE in 1934 for her indefatigable commitment to the advancement of medicine for women. Not all Harley Street women were decorated, but others such as Ellaby, Gordon, Davies-Colley, Flemming and Vaughan-Sawyer achieved a high reputation amongst their peers in the medical profession. Johanna Geyer-Kordesch argued that:

when the first handful of women won their degrees, domestic ideology was dented beyond repair. This ideological impact, rather than their small number, gives them undeniable historical significance.¹⁹⁰

¹⁸⁶ *Ibid.*, pp. 144-165 and 185-186.

¹⁸⁷ Louisa Garrett Anderson was awarded the CBE in 1917. May Thorne was sent to Malta as a surgeon with the RAMC and awarded the OBE following the war. Stoney was awarded the 1914 Star and the OBE, Cambridge also conferred on her the DMRE *Honoris Causâ* for her work.

¹⁸⁸ Scharlieb, *Reminiscences*, p. 206.

¹⁸⁹ Dawkins, 'Walker', p. 6.

¹⁹⁰ Johanna Geyer-Kordesch, 'Women and Medicine', 'Women and Medicine', in W. F. Bynum and Roy Porter, (eds.) *Companion Encyclopedia of the History of Medicine*, Vol. 2, (London, 1977), p. 895.

Whilst some Harley Street women were not particularly distinguished, predominantly those who arrived in the Street around 1914, such as Kate Addison and Hedda Alstrom, the majority (including Mary Scharlieb, Florence Boyd, Jane Walker, Maud Chadburn, Ethel Vaughan-Sawyer, Eleanor Davies-Colley, Charlotte Ellaby, Ada Stoney, May Thorne, Louisa Garrett Anderson) made a significant contribution to the advancement of women's opportunities in medicine. Some such as Davies-Colley, Chadburn, Louisa Garrett Anderson and Walker founded and ran hospitals and created new positions in medicine for other women medical practitioners. Chadburn and Thorne had wards named after them; Thorne for her fund raising and support for the Royal Free and Chadburn at St George's Hospital because of her surgical work.¹⁹¹ Through their personal successes, several of the cohort including Scharlieb, Ellaby and Gordon, paved the way for future generations of women medical practitioners by being elected to posts, which had hitherto been the preserve of their male colleagues, and by breaking down male prejudices existing in the medical profession. Moreover, many of their medical colleagues described Stoney, Chadburn, Scharlieb, Walker and Davies-Colley as "pioneers" in their areas of expertise.

Others in the group, for example, Vaughan-Sawyer, Flemming, Boyd and Scharlieb set a high standard of academic excellence, and through their distinguished careers and their academic accolades they were an asset to

¹⁹¹ D. C. S. 'May Thorne', *BMJ*, Nov. 3, 1951, RFHSM PC, Book 8, part 1. Gould and Uttley, *St George's*, p. 54.

the women's movement and an inspiration to the next generation of women medical students. In common with their male counterparts, the Harley Street women were part of the élite and their role in the history of medicine validates a study of their lives and careers. Without recognition of their presence, any history of Harley Street would be incomplete.

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CHAPTER 8

Conclusion

Throughout the course of the twentieth century, there has been a pervasive view that Harley Street practitioners formed an élite corps among medical practitioners in Great Britain. Despite this long established view, there has been no attempt systematically to examine this belief. Even though its importance as a medical locality has long been recognised, historians of medicine have given very little consideration to the development of Harley Street as a medical area. This thesis has, therefore, attempted to correct this lacuna in the historical literature. Comparisons were made with two other groups of medically qualified individuals in London, those who practiced in the Harley Street Area and those in Greater London for the years 1845, 1880 and 1914, to further corroborate the professional accomplishments of those in Harley Street.

For historians, a prosopographical analysis is most suitable for an examination of élites, as historical data is more likely to be available for this group than for those who were socially or professionally less prominent. In order for generalisations about such an entity to have any historical veracity, information must relate to the majority of individuals being studied. If data were available only for 10 or 15 per cent of the cohort, this would become a biased random sample and thus unrepresentative of the group as a whole. Hence, only sources that are complete and regular in form for a large proportion of the group can be used. Other material can,

however, be used to complement and enhance the findings from the data analysis.

The results of the prosopographical investigation of all registered medical practitioners who arrived in Harley Street between 1845 and 1914 provided overwhelming historical and empirical evidence that these practitioners not only achieved unparalleled pre-eminence in the medical community, but also were unsurpassed in their professional standing. The group's reputation was assessed by examining their many academic qualifications and achievements; it was found that they not only wielded considerable collective editorial authority in their role as editors of a wide range of medical journals, hospital reports, manuals and dictionaries, but that many in Harley Street greatly contributed to the professionalisation of medicine at the end of the nineteenth century by creating new medical specialities, establishing new specialist hospitals, taking prominent roles in medical societies, delivering renowned public lectures, publishing in the main medical journals and generally disseminating their new found knowledge and technical skills. Indeed, over half of these men were medical or surgical specialists or had a special interest in one or more subject. Thus, by the first quarter of the twentieth century, Harley Street was regarded as a centre for medical specialism.

This thesis has demonstrated that the Harley Street group followed a well-defined career trajectory. The majority of these men pursued the highest qualifications attainable, thereafter started their career path by taking up their training in the more eminent and well established teaching

hospitals. Most were also keen to further their careers by publishing a substantial collective body of work, taking on the role of editor of well-established journals, notably the *BMJ*, creating dictionaries or encyclopaedias of medicine and establishing new journals. Many were successful in securing coveted posts in hospitals whilst setting up their own private practices.

By the time they arrived in Harley Street, they were eminently qualified men who possessed a wealth of experience and the indispensable kudos that enabled them to inhabit such a privileged address. Once established they used this opportunity to create new specialists hospitals and new specialised medical disciplines. Whilst there were other exceptional medical practitioners in other areas of London who followed similar career paths, the Harley Street group were, indisputably, an identifiable body of medical excellence, recognised not only by the medical profession but also by the public who flocked to them for medical advice and treatment.

This thesis has also shown that Harley Street became a progressively more fashionable choice for medical practitioners wishing to establish a practice in London. By the 1860s, Harley Street was regarded as the holy grail of the medical world, attracting some of the finest medical practitioners in Victorian London who aspired to live a life ensconced in the highest echelons of society. Such was the cachet of a Harley Street address that even having a practice in the Harley Street Area was not good enough: more than one-third of the cohort moved from one of these perpendicular

and parallel streets to Harley Street itself. This address represented the pinnacle of their career trajectory for virtually the entire cohort.

Whilst to some critics, Harley Street medical practitioners were regarded as inhabiting a “distinguished address”, having arrived at a “grand destination” and offering talismanic medical cures to their patients, to other opponents they incurred moral opprobrium for their ostensible avarice, greed and vanities along with alleged insensitivities to the needs of their patients. In spite of these often misguided perceptions, Harley Street was recognised by patients and the medical profession as a centre of professional excellence: this thesis has amply demonstrated that such excellence was warranted.

From the extant information on social background, it was found that whilst many of these men came from middle class backgrounds and many came from medical families, they, nevertheless, earned their qualifications on their own merits. For those who already had relatives practising on the Street, which gave some of the cohort an advantage in setting up their Harley Street practice, this did not preclude them from gaining the requisite hard-earned accomplishments and merits before arriving on the Street. In fact, some sons, such as Anderson Critchett became more prominent than their fathers.

The vast majority, almost 9 out of every 10 Harley Street medical practitioners, were qualified MD, MB, FRCP, FRCS or MRCP or held a combination of a medical degrees and fellowships; thus, they were amongst

the most highly qualified medical practitioners in England. Additionally, 24 of the Harley Street cohort were elected FRS, which was a considerable number because only 151 FRSs from 1845 to 1914 had medical qualifications. Moreover, in 1914, Harley Street men received ten times more prizes, scholarships and awards during their graduate years than other medical practitioners either in the Harley Street Area or in Greater London.

By using Rivington's definition of "pure physicians" and "pure surgeons", 39 per cent of Harley Street men would be defined as "pure physicians" and 37 per cent as "pure surgeons". To this end, Harley Street may be seen as a nucleus of the medical and surgical élite. Almost half of all the medical practitioners registered in Harley Street in 1914 were Fellows of the Royal Colleges of Physicians or Surgeons whilst the percentage of Fellows in the Harley Street Area was 17 per cent. However, the number of Fellows in Greater London in 1914 was dramatically lower; amounting to less than one per cent. The difference is significant: it confirms that up to the onset of the Great War, Harley Street was the preferred address for élite medical practitioners in London. Their academic success was reflected in their hospital appointments as three quarters of Harley Street men held a consulting or senior staff post in a teaching or a general hospital and more than half had multiple posts, whereas two thirds in the Harley Street Area and only ten per cent in Greater London held such posts.

Though Digby's analysis of GPs across Britain revealed that up to 50 per cent were members of medical societies, almost 90 per cent of Harley

Street men were members of at least one medical society. Harley Street had a clear geographical advantage, since London was the hub of medical societies in the period and Harley Street was at its centre. Whilst Digby and Loudon showed that up to 50 per cent of GPs and physicians published material, Harley Street practitioners were more prolific since at least 85 per cent published their work. The percentage of Harley Street practitioners who had received their MD before or during their time in Harley Street and who had published was more than three times greater than in Digby's study. Of the Harley Street group who had MDs, 93 per cent published some aspect of their work.

This thesis has also demonstrated that women in Harley Street not only shared similar aspirations to their male neighbours, but they also had similar concerns: the women no more wanted to be at the north end of Harley Street than the men did. These determined women were professionally and socially ambitious, coveted highly desirable medical posts, sought recognition for their work, built large and lucrative practices and removed a number of professional barriers. Many were active in medical societies and held senior posts in a number of prominent medical associations. Moreover, these women regarded entertaining at home as essential to the role of a consultant, as did their male counterparts.

Concerns about being marginalized by the male medical community surfaced when Jane Walker, a member of the first generation of women doctors, acknowledged it was often the case that some women medical practitioners lived solitary lives in the provinces, as they were outnumbered

by a ratio of 20 to 1. However, since Harley Street had a geographical advantage, being in the centre of London, women had greater opportunities for socialising and professional interaction with their male and female colleagues. Not only did they receive more referrals to other doctors than women medical practitioners in the provinces, but they also had more opportunities to attend meetings at organisations and clubs, which were open to female members.

Approximately 80 per cent of the female cohort were in practice before arriving in Harley Street. The move to Harley Street from another practice address represented the usual upward career progression, as was seen with the male medical practitioners. The majority of women stayed an average of 19 years in Harley Street, during which time they built up their private practices, and 38 per cent of these retired at their Harley Street address. For two thirds of the cohort, their time in Harley Street represented increasing advancement in their profession. Mary Ann Elston showed that only a "minute number" of the first generation of women medical practitioners in Britain managed to procure appointments as a clinical assistant or resident medical officer, the majority of the Harley Street female cohort managed to take up such appointments.

A number of Harley Street women played key roles in significantly advancing the opportunities for women through the creation of new hospitals. Though it was rare for the first generation of female medical practitioners across Britain to become specialists, all of the first generation of Harley Street women specialised in a particular area. Approximately half

of the second-generation of Harley Street women decided to concentrate their medical career in one area and the majority of these women were active participants in medical societies. Just over half of the female cohort had their work published in a scientific journal or medical reference books. Several of these women published in specialist journals. Thus it may be seen that the first women to arrive in Harley Street were a distinguished group of medical practitioners.

If the task of the historian is to humanise history by providing details of the lives of the many people who played a pivotal role in shaping historical events, this thesis has shown unequivocally that a prosopographical analysis enables the historian to speak with greater empirical and historical confidence about a group of medical practitioners without making unsubstantiated and overly simplistic generalisations. By creating a database, it was possible to follow the lives of all 657 men and 24 women in Harley Street in considerable detail, thereby eliminating potential distortions and misinterpretations inherent in a smaller subset of such a group.

The database could provide future historians with material to explore connections amongst various specialised groups of medicine (e.g., neurology, ophthalmology and dermatology), as well as to undertake a more comprehensive analysis of the inner-workings of the various activities that each of these groups followed separately. Further investigations could be pursued to determine the interconnections of the cohort, in relation to their place of education and training and subsequent hospital posts, by examining

their academic and professional relationships. Finally, the database may also be used as a model for those who wish to examine Harley Street after the First World War.

APPENDIX A

Table 1.1

Population and Sample sizes across Time Regions in London

Year	Harley St.	Harley St. Area	Greater London	Total Registered in the <i>Directory</i> for London
1845	8	19	101	2,027
1880	57	120	197	3,947
1914	278	339	303	6,064
TOTAL	343	478	601	12,038

Sample of Harley Street Cohort

From the *London and Provincial Medical Directory*

1845

Existing

Clarke, Charles Mansfield, Number ?

Coles, James, Number 25

Hancock, Hy., Number 59

Macintyre, Wm., Number 84

Maclure, William, Number

Monro, Edw. Thos., Number 87

Riadore, Evans, Number 73

South, H.H., (should be Southey) Number 1

1846

New Comers:-

Lattey, P.P., Number 29

McGrigor, Sir James, Number 3

Oswin, Charles, Number 72

Tuson, Edward William, Number 15

1847

New Comers:-

Fraser, Number ?

Upper Harley Street

Fitton, Number 50

1848

New Comers:-

Garrod, A. B. Number 63

Quain, Rich., Number 23

1849

New Comers:-

Chambers, Richard, Number 65

Downing, Charles T., Number 24

Elmore, J. R. Number 27

APPENDIX B

Table 2.1

Registered Location of London Practices in 1790. ¹

District	Surgeons	Apothecaries	Physicians
North London	8%	0%	0%
South London	5%	1%	5%
South East London: Southwark	2%	1%	0%
South West London: Chelsea	1%	0%	0%
South West London: Fulham	1%	0%	0%
South West London: Westminster	3%	0%	3%
South West London: St. James's	2%	5%	7%
East London	7%	17%	1%
West London: Bloomsbury and Soho	4%	1%	8%
West London: Mayfair	6%	1%	20%
West London: Marybone	2%	0%	2%
West London: Oxford Street	3%	0%	0%
West London: Poland Street	2%	0%	0%
West London: Other	4%	3%	8%
City	25%	35%	24%
London EC: Holborn	8%	23%	16%
Hospital Address	0%	13%	1%
British Library	0%	0%	1%
Address uncommunicated	16%	0%	4%
District Not Known ²	1%	0%	0%
Total recorded in London	100% (n = 429)	100% (n = 110) ³	100% (n = 106) ⁴

¹ See also Peter J., Atkins, *The Directories of London, 1677-1977*, (London, 1932), p. 46.

² This refers to streets whose names were duplicated in a number of different areas therefore the street in which these medical practitioners practiced could not be located accurately.

³ Included in this number were 10 partnerships of 2 people and one of 3 people. I have counted the individuals.

⁴ Wilkes & Barfoot, *The Universal British Directory*, contained addresses outside London such as Liverpool, Durham and Cambridge, these were excluded for the purposes of the data set above.

Table 2.2
Registered address prior to arrival in Harley Street between
1845-1914

Area/Country	Number	Percentage (%)
London – N and NW	41	6.24%
London – SE and SW	43	6.54%
London – EC	24	3.65%
London – W and WC	72	10.96%
London – W (Harley St Area)	242	36.83%
England (excluding London)	64	9.74%
Ireland, Scotland and Isle of Wight	14	2.13%
Overseas, Navy	16	2.44%
Hospital – Resident Posts	52	7.91%
Newly Qualified	54	8.22%
Social Club	7	1.07%
Unknown ⁵	28	4.26%
Total	657	99.99%

Table 2.3
Period of Registration in Harley Street

Number of years in Harley Street	Number of practitioners	Percentage of practitioners
Up to one year	70	10.65%
2 to 10 years	267	40.64%
11 to 20 years	129	19.63%
21 to 30 years	97	14.76%
31 to 40 years	66	10.05
41 to 50 years	20	3.04%
51 to 60 years	7	1.07
61 years	1	0.15%
Total	657	100.00%

⁵ Figure includes 17 whose registered address was not in *The Medical Directory* and were pre 1859, the date of the first *Medical Register*, 2 others had previous address as "address uncommunicated" in *The Medical Directory*.

Table 2.4

Registered address following departure from Harley Street

Area/Country	Number	Percentage (%)
London – N and NW	24	3.65%
London – SE and SW	21	3.20%
London – EC	8	1.22%
London – W and WC	59	8.97%
London – W (Harley St Area)	183	27.85%
England (excluding London)	15	2.28%
Ireland, Wales	2	0.30%
Overseas	2	0.30%
Hospital – Resident Posts	8	1.22%
None	319	48.55%
Social Clubs, Travelling and Army	16	2.44%
Total	657	99.98%

APPENDIX C

Table 3.1

Medical Degrees and Licences, Harley Street, 1845-1914

By Highest Qualifications

QUALIFICATIONS	PERCENTAGE %	NUMBER
FRFPS/FRCP/MD/MS	0.15%	1
FRCP/FRCP(i)/MD/LSA	0.15%	1
FRCP/FRCP(i)/MD	0.30%	2
FRCP/FRCP(Edin.)/MD	0.30%	2
FRCP/FRCP(Edin.)/MD/LRCS/LM	0.15%	1
FRCP/FRCS/MD/MS	0.46%	3
FRCP/FRCS/MD/BS	0.15%	1
FRCP/FRCS/MD/LSA	0.61%	4
FRCP/FRCS/MD	0.61%	4
FRCP/FRCS/MB/LSA	0.15%	1
FRCP/FRCS/MB	0.15%	1
FRCP/FRCS/LSA	0.30%	2
FRCP/MD/MS	0.91%	6
FRCP/MD/BS	0.61%	4
FRCP/MD/BS/MRCS/LSA	0.15%	1
FRCP/MD/BS/MRCS	1.22%	8
FRCP/MD/MRCS/LSA	1.52%	10
FRCP/MD/MRCS	3.35%	22
FRCP/MD	2.44%	16
FRCP/MD/LSA	0.46%	3
FRCP/MB/MRCS	0.76%	5
FRCP/MB/MS/MRCS/LSA	0.15%	1
FRCP/MB/BS/MRCS/LSA	0.15%	1
FRCP/MB/BS/MRCS	0.30%	2
FRCP/MB/BS	0.30%	2
FRCP/MB/MRCS	0.15%	1
FRCP/MB/LSA	0.15%	1
FRCP/MB	1.37%	9
FRCP/MS	0.15%	1
FRCP/BS/MRCS	0.15%	1
FRCP/MRCS	0.15%	1
FRFPS/MD/MS	0.30%	2
FRFPS/LRCP/LSA	0.15%	1
FRCS/FRCS(Edin.)/MD/MS/LRCP/LM	0.15%	1
FRCS/FRCS(Edin.)/MB/MS	0.15%	1
FRCS/MD/MRCP/MRCS/LSA	0.15%	1
FRCS/MD/MRCP/LSA	0.15%	1
FRCS/MD/MRCP or LRCP	0.46%	3
FRCS/MD/MS/MRCP	0.30%	2

QUALIFICATIONS	PERCENTAGE %	NUMBER
FRCS/MD/MS/LRCP/LM	0.15%	1
FRCS/MD/MS/LRCP	1.22%	8
FRCS/MD/MS/MAO	0.15%	1
FRCS/MD/MS	0.91%	6
FRCS/MD/BS/MRCP or LRCP	1.67%	11
FRCS/MD/BS/MRCS	0.30%	2
FRCS/MD/BS/BAO	0.15%	1
FRCS/MD/BS/LM	0.15%	1
FRCS/MD/BS/LSA	0.15%	1
FRCS/MD/MD/BS	0.91%	6
FRCS/MD/MRCP	0.15%	1
FRCS/MD/LRCP/LM	0.15%	1
FRCS/MD/LRCP	0.30%	2
FRCS/MD/LSA	0.46%	3
FRCS/MD	0.76%	5
FRCS/MB	0.76%	5
FRCS/MB/MS/LRCP	1.37%	9
FRCS/MB/MS/LSA	0.76%	5
FRCS/MB/MS	1.22%	8
FRCS/MB/BS/MRCP	0.15%	1
FRCS/MB/BS/LRCP	3.81%	25
FRCS/MB/BS/LM	0.15%	1
FRCS/MB/BS	2.13%	14
FRCS/MB/MRCP or LRCP	1.37%	9
FRCS/MB/LSA	0.15%	1
FRCS/MS/LRCP	0.61%	4
FRCS/BS/LRCP	0.30%	2
FRCS/MRCP/LSA	0.15%	1
FRCS/MRCP	0.15%	1
FRCS/LRCP/LSA and/or LM	2.44%	16
FRCS/LRCP	5.48%	36
FRCS/LSA and/or LM	3.35%	22
FRCS only	2.59%	17
MD/MS/MRCP	1.07%	7
MD/MS/MRCP/MAO	0.15%	1
MD/MS/LRCP/LRCS/LM	0.46%	3
MD/MS/LRCP/LRCS	0.30%	2
MD/MS/LRCP	0.30%	2
MD/MS/LSA/LM	0.15%	1
MD/MS/MRCP/MRCS	0.30%	2
MD/MS/MRCS/LRCP	0.15%	1
MD/MS/MRCS	0.46%	3
MD/MS/LSA	0.15%	1
MD/MS/LM	0.15%	1
MD/MS/MAO	0.15%	1
MD/MS	0.76%	5
MD/BS/MRCP/MRCS/LSA	0.15%	1
MD/BS/MRCP/MRCS	1.22%	8
MD/BS/MRCP/LM	0.15%	1
MD/BS/MRCP	0.46%	3
MD/BS/MRCS/LRCP	0.46%	3

QUALIFICATIONS	PERCENTAGE %	NUMBER
MD/BS/MRCS/LSA	0.30%	2
MD/BS/LM	0.15%	1
MD/BS	1.67%	11
MD/BO	0.15%	1
MD/MRCP/MRCS/LSA	0.76%	5
MD/MRCP/MRCS	1.83%	12
MD/MRCP/LSA/LM	0.15%	1
MD/MRCP/LSA	0.15%	1
MD/MRCP	1.37%	9
MD/MRCS/LRCP	1.52%	10
MD/MRCS/LSA and/or LM	2.28%	15
MD/MRCS	0.61%	4
MD/LRCP/LRCS/LSA and/or LM	0.30%	2
MD/LRCP and/ or LRCS	0.76%	5
MD/LRCS/LM	0.15%	1
MD only	1.52%	10
MB/LRCP	0.15%	1
MB/MS	1.52%	10
MB/BS	1.52%	10
MB/MS/MRCP	0.46%	3
MB/MS/LRCP/LRCS	0.15%	1
MB/MS/ LRCP/MRCS	0.15%	1
MB/BS/MRCP/MRCS	0.61%	4
MB/BS/MRCS/LRCP	1.37%	9
MB/BS/MRCS or LRCS	0.76%	5
MB/BS/LSA or LM	0.30%	2
MB/MRCP/MRCS/LSA	0.15%	1
MB/MRCP/MRCS or LRCS	0.46%	3
MB/MRCP/LRCS/LM	0.15%	1
MB/MRCP	1.07%	7
MB/MRCS/LRCP/LSA	0.15%	1
MB/MRCS/LRCP/BAO	0.15%	1
MB/MRCS/LRCP	0.30%	2
MB/MRCS/LSA	0.30%	2
MB/MRCS	0.46%	3
MB only	0.30%	2
MRCP/MRCS	0.46%	3
MRCP only	0.15%	1
LRCP/LRCS/LM	0.30%	2
LRCP/LRCS	0.61%	4
LRCP/LSA or LM	0.30%	2
LRCP only	0.15%	1
MRCS/LRCP/LM and/or LSA	1.37%	9
MRCS/LRCP	5.94%	39
MRCS/LSA	1.82%	12
LRCS/LM	0.15%	1
MRCS only	2.29%	15
LRCS only	0.15%	1
LSA only	0.76%	5
Total	100%	657

Table 3.2
Medical Degrees held by Medical Men registered in Harley Street,
1845-1914.

By Highest Qualification

University and degree earned	Percentage – at date of arrival in Harley St.	Number – at date of arrival in Harley St.	Percentage of additional degrees at date of departure	Number of additional degrees at date of departure
MD, 60 with MS or BS				
London	15.37%	85	1.22%	8
Scotland	13.70%	90	1.07%	7
Oxbridge	5.48%	30	1.22%	8
Others–Europe ¹	4.47%	30	0.15%	1
Durham	2.59%	18		
Ireland ²	2.59%	17		
Others – England	0.61%	2		
Canada	0.46%	3		
Total		<i>n</i> = 275		<i>n</i> = 24
MB, 117 with MS or BS				
London	9.44%	62		
Oxbridge	8.07%	53		
Scotland	5.63%	37		1
Durham	1.37%	9		
Others ³	1.07%	7		1
Total		<i>n</i> = 168		<i>n</i> = 2
MS, 91 with MD or MB				
Scotland	10.20%	67	0.15%	1
London	3.20%	21	0.15%	1
Oxbridge	1.22%	8	0.15%	1
Canada	0.60%	4		
Others ⁴	0.46%	3	0.15%	1
Total		<i>n</i> = 103		<i>n</i> = 4
BS, 122 with MD or MB degrees				
Oxbridge	9.44%	62		

¹ This was comprised of one from each of the following universities: - Basle, Erlangen, Freiburg, Giessen, Parma, Pavia, Vienna, Strasburg and Wurtzburg and 4 from Paris, 2 from Berlin and 15 from Brussels.

² Ten were from Queen's University (in 1882 the name was changed to the Royal University) and seven from University College Dublin.

³ This was comprised of one from each of the following universities: - Adelaide, Ontario and Toronto, Dublin and Liverpool.

⁴ One from each of the following universities: St Andrews, Durham and Bishops Montreal. The additional MS at departure was from Royal (formerly Queen's) University Ireland.

University and degree earned	Percentage – at date of arrival in Harley St.	Number – at date of arrival in Harley St.	Percentage of additional degrees at date of departure	Number of additional degrees at date of departure
London	6.85%	45	0.30%	2
Scotland	2.44%	16		
Others ⁵	0.30%	12	0.15%	1
Durham	1.07%	7		
Total		<i>n</i> = 142		<i>n</i> = 3

⁵ One from each of the following universities: Adelaide and Ontario and 6 from and 4 from Liverpool.

Table 3.3
Licences held by Medical Men registered in Harley St.,
1845-1914. By Highest Qualification.

Licensing Bodies	Percentage – at date of arrival in Harley St.	Number – at date of arrival in Harley St.	Percentage of additional licences at date of departure	Number of additional licences at date of departure
FELLOWS, PHYSIC: All with medical or surgical degrees				
London/England(FRCP) ⁶		72	6.09%	40
Edinburgh (FRCP, Edin.)	0.76%	5	0.46%	3
King's and Queen's College of Physicians, Ireland (FKQCPI)	0.30%	2	0.15%	1
Total		<i>n</i> = 75		<i>n</i> = 45
FELLOWS, SURGERY: 162 with medical or surgical degrees				
England (FRCS)		196	3.50%	23
Edinburgh (FRCS Edin.)	3.50%	23	0.30%	2
Ireland (FRCSI)	1.52%	10		
Glasgow ⁷ (FRFPS)	0.46%	3	0.15%	1
Total		<i>n</i> = 232		26
MEMBERS, PHYSIC: All with medical or surgical degrees. 40 with MRCS				
London/England (MRCP)		82	0.61%	4
Edinburgh (MRCP, Edin.)	0.61%	4		
Total		<i>n</i> = 90		<i>n</i> = 4
MEMBERS, SURGERY: 62 with medical or surgical degrees.	42.16%	131	0.30%	2
LICENTIATE, PHYSIC: 6 with LRCS				
London/England (LRCP)		9		
Licentiate, Surgery:				
Edinburgh (LRCS, Edin.)		2		
Licentiate, Apothecaries				
LSA only		5		

⁶ When the RCP introduced its charter in 1843, the licence changed from RCP London to RCP England.

⁷ Despite its name as the Royal College of Physicians and Surgeons, this was a college of surgeons. See Rivington, *Medical Profession*, (London, 1888), pp. 241, 259-261.

Table 3.4
Medical Qualifications, 1845
– By Highest Qualifications

Qualification	Harley Street Percentage	Harley Street Number	Harley Street Area Percentage	Harley Street Area Number	Greater London Percentage	Greater London Number
Population/Sample		Population <i>n</i> = 8		Population <i>n</i> = 19		Population ÷ 2,027(5%) <i>n</i> = 101 ⁸
FRCP/MD	37.50%	3	26.32%	5	0.99%	1
FRCP			5.26%	1	0.99%	1
FRCS	12.50%	1	31.58%	6	5.94%	6
MD/MRCP	12.50%	1	15.79%	3	2.97%	3
MD	12.50%	1			5.94%	6
MD/MRCS			5.26%	1	2.97%	3
MB/MRCS			5.26%	1	0.99%	1
MRCP/MRCS					0.99%	1
MRCS only	12.50%	1	10.53%	2	28.72%	29
MRCS/LSA	12.50%	1			36.63%	37
LSA					12.87%	13
Total ⁹	100%	8	100%	19	100%	101

Table 3.5
Place of MD, 1845

University	Harley Street Percentage	Harley Street Number	Harley Street Area Percentage	Harley Street Area Number	Greater London Percentage	Greater London Number
London	12.50%	1			1.98%	2
Oxbridge	12.50%	1	10.53	2	0.99%	1
Scotland	25.00%	2	42.11	8	6.93%	7
Rest of Europe	12.50%	1			0.99%	1
Not recorded in Directory					1.98%	2
Total		(<i>n</i> = 5)		(<i>n</i> = 10)		(<i>n</i> = 13)

⁸ Population includes 27 whose returns were received late, pp. ix-xii, *Medical Directory*, 1845. Population own count, as there was no total in the *Medical Directory*.

⁹ Difference due to rounding.

Table 3.6
Medical Qualifications, 1880
– By Highest Qualifications

Qualification	Harley Street Percentage	Harley Street Number	Harley Street Area Percentage	Harley Street Area Number	Greater London Percentage	Greater London Number
Population/Sample		Population <i>n</i> = 57		Population <i>n</i> = 120		Population 3,947 + 20 (5%) <i>n</i> = 197
FRCP/FRCS/MD	3.51%	2	1.67%	2		
FRCP/FRCS/MB			1.67%	2		
FRCP/MD/MRCS	12.28%	7	9.67%	11		
FRCP/MD	12.28%	7	14.17%	17	0.51%	1
FRCP/MB			2.50%	3	1.01%	2
FRCP/MRCS	1.75%	1				
FRCS/MD	3.51%	2			2.03%	4
FRCS/MB	5.26%	3	7.50%	9	2.54%	5
FRCS/LRCP	5.26%	3	0.83%	1		
FRCS/LSA	3.51%	2	3.33%	4	5.08%	10
FRCS	8.77%	5	10.83%	13	2.54%	5
MD/MRCP/MRCS	8.77%	5	3.33%	4		
MD/MRCP	3.51%	2	2.50%	3	2.03%	4
MD/CM (MCh)			0.83%	1	2.03%	4
MD/MRCS	5.26%	3	3.33%	4	7.61%	15
MD/LRCS			0.83%	1	2.03%	4
MD/LSA	1.75%	1			1.52%	3
MD	3.51%	2	4.17%	5	7.11%	14
MB/MRCP/MRCS	1.75%	1				
MB/MRCP/LRCS	1.75%	1	0.83%	1		
MB/MRCP	3.51%	2	1.67%	2		
MB/MRCS/LRCP			0.83%	1		
MB/MRCS	1.75%	1	1.67%	2	1.01%	2
MB/LRCS					1.01%	2
MB					1.01%	2
MRCP/MRCS			3.33%	4		
MRCP/LSA					0.51%	1
LRCP/MRCS			5.83%	7	13.20%	26
LRCP/LRCS					4.57%	9
LRCP/LSA					2.03%	4
LFPS			0.83%	1		
MRCS/LSA	5.26%	3	8.33%	10	21.32%	42
MRCS	5.26%	3	9.17%	11	11.68%	23
LRCS	1.75%	1	0.83%	1	1.52%	3
LSA only					4.06%	8
LM only					2.03%	4
Total	99.96%	57	100.48%	120	99.99%	197

Table 3.7
University of MD, 1880

University	Harley Street Percentage	Harley Street Number	Harley Street Area Percentage	Harley Street Area Number	Greater London Percentage	Greater London Number
London	24.56%	14	11.67%	14	3.05%	6
Scotland	24.56%	14	15.53%	19	13.20%	26
Oxbridge	5.26%	3	5.00%	6	3.05%	6
Ireland	1.75%	1	0.83%	1	1.02%	2
Rest of Europe	1.75%	1	5.83%	7	3.05%	6 ¹⁰
U. S.			0.83%	1	1.52%	3
Total		(n = 33) ¹¹		(n = 48) ¹²		(n = 49)

¹⁰ One from the following: Durham, Pisa, Giessen, Paris, Brussels and Breslam.

¹¹ Two men from Harley Street had a double MD: - A.B. Garrod qualified MD from London and Oxford and S. Fenwick qualified MD from Durham and St Andrew's. Therefore, total number of those with MD was 31.

¹² In the Harley Street area, two medical practitioners (J F Churchill and M Roth) had two MDs: from Pavia and St. Andrews and from Pavia and Vienna respectively. Thus, the number of those with an MD was 46.

Table 3.8
Medical Qualifications, 1914
By Highest Qualifications

Qualification	Harley Street %	Harley Street Number	Harley St. Area	Harley St. Area Number	Greater London	Greater London Number
Population/Sample		<i>n</i> = 278		<i>n</i> = 399		6,604+ 20(5%) <i>n</i> = 330
FRCP/FRCS/MD or MB	1.44%	4	0.50%	2		
FRCP/FRCS	0.36%	1				
FRCP/MD or MB	8.99%	25	1.25%	5	0.61%	2
FRCP only	0.36%	1	0.25%	1		
FFPS/FRCS/MD	0.36%	1				
FFPS/MD/MS	0.36%	1				
FRCS/MD or MB	27.34%	76	3.26%	13	0.30%	1
FRCS/MS or BS	2.16%	6				
FRCS/MRCP or LRCP	5.76%	16	9.28%	37	1.21%	4
FRCS/LSA	1.44%	4	1.00%	4		
FRCS	1.08%	3	1.50%	6		
MD/MRCP or LRCP	3.60%	10	1.75%	7	3.94%	13
MD/MS or BS	13.31%	37	6.27%	25		
MD			34.59%	138	15.45%	51
MD/MRCS/LSA or LM	1.80%	5			0.30%	1
MD/MRCS	0.72%	2	1.50%	6	1.82%	6
MD/MRCS/LRCP	1.44%	4	1.50%	6		
MD/LRCP and/ or LRCS	0.36%	1			0.30%	1
MD/LSA					0.91%	3
MB/MRCP or LRCP/MRCS	1.80%	5	0.25%	1	1.21%	4
MB/MRCS/LSA	0.36%	1				
MB/MRCS or LRCS	0.36%	1	0.75%	3	2.73%	9
MB/MS/MRCS	0.36%	1				
MB/MS or BS	10.43%	29	19.55%	78	21.52%	71
MB	0.36%	1	0.25%	1	3.03%	10
MS			0.25%	1	0.30%	1
BS/MRCP or LRCP/MRCS	0.72%	2				
BS/LRCP	0.36%	1				
MRCP/MRCS and/or LRCP	0.72%	2	0.25%	1		
LRCP/LRCS or LRFPS			0.25%	1	10.61%	35
LRCP/LRCS/LFFPS/LSA	0.36%	1				
LRCP/LRCS/LFFPS	0.72%	2				
LRCP/LSA or LM					1.82%	6
LRCP or LRFPS	0.36%	1			0.30%	1
MRCS/LSA	1.08%	3	0.75%	3	5.15%	17
MRCS/LRCP/LM/LSA	0.36%	1				
MRCS/LRCP	9.35%	26	12.53	50	23.03%	76
MRCS or LRCS	1.08%	3	2.51%	10	1.21%	4
LMSSA or LSA	0.36%	1			4.24%	14
Total	100.43%	278	99.94%	399		300

Table 3.9
University of MD, 1914
Medical Practitioners

University	Harley Street Percentage	Harley Street Number	Harley Street Area Percentage	Harley Street Area Number	Greater London Percentage	Greater London Number
London	14.39%	40	19.05%	76	3.33%	11
Oxbridge	6.16%	17	10.78%	43	3.03	10
Durham	2.88%	8	2.76%	11	2.12%	7
Manchester	0.15%	1				
Scotland	11.87%	33	8.27%	33	6.36%	21
Ireland ¹³	2.52%	7	0.50%	2	0.61%	2
Rest of Europe	3.60%	10	6.52%	26	4.55%	15
U. S. / Canada	1.44%	4	0.50%	2	0.30%	1
Not recorded in Directory			0.50%	2	3.64%	12
Total		(n = 120)		(n = 195)		(n = 79)

Table 3.10
Prizes, Scholarships and Medals
Awarded During Student Years

Year	Harley Street Percentage	Harley Street Number	Harley St. Area Percentage	Harley St. Area Number	Greater London Percentage	Greater London Number
1845	None		None		None	
1880	28.07%	16	5.00%	6	6.09%	12
1914	35.61%	99	15.54%	62	3.03%	10

¹³ For Harley St.: • 4 UCD and 3 RUI. For Harley St. Area and outside Harley St., UCD 1, RUI, 1.

Table 3.11

Medical Training, Harley St. Medical Men 1845-1914

Medical Schools	Percentage – at date of arrival in Harley St.	Count – at date of arrival in Harley St.
LONDON		
St. Bartholomew's	16.44%	108
UCH	15.37%	101
The London	10.05%	66
St. Thomas's	9.59%	63
Guy's	6.85%	45
The Middlesex	6.54%	43
King's	6.09%	40
St. Mary's	5.02%	33
St. George's	3.96%	26
Charing Cross	2.74%	18
Westminster	1.52%	10
PROVINCIAL MEDICAL SCHOOLS		
Cambridge Medical School/Addenbrook's Hospital	10.35%	68
Oxford Medical School/Radcliffe Infirmary	2.74%	18
Durham College of Medicine/Newcastle Infirmary ¹⁴	2.59%	17
Owens' College Manchester/Royal Infirmary ¹⁵	0.91%	6
Birmingham/ General and Queen's Hospitals	0.76%	5
Scotland/Ireland		
University of Edinburgh/Royal Infirmary	11.57%	76
Trinity /Sir Patrick Dun's Hospital ¹⁶	1.67%	11
University College Dublin/ St Vincent's Hospitals	1.98%	13
University of Glasgow/Western Infirmary and Royal Infirmary)	3.04%	20
University of Aberdeen/Royal Infirmary	2.74%	18
Queen's College Cork /South Infirmary and Cork General Hospital	0.76%	5
EUROPE – UNIVERSITY		
Paris	9.28%	61
Vienna	8.07%	53
Berlin	5.18%	34
Leipzig	2.13%	14
Strasbourg	1.37%	9
Brussels	1.07%	7
Freiburg	0.76%	5
OTHERS		
Dental Hospital London	2.13%	14
Not Listed in the Medical Directory	9.44%	62

¹⁴ Students could also study in a range of other institutions, for a complete list see Rivington, *Medical Profession*, (1888), pp. 652-655

¹⁵ *Ibid.*

¹⁶ 11 from Trinity College and 13 from University College Dublin.

Table 3.12
Medical Training 1880

Medical Schools	Harley Street %	Harley St. Number	Harley St. Area %	Harley St. Area Number	Greater London %	Greater London Number
LONDON		<i>n</i> = 57		<i>n</i> = 120		<i>n</i> = 197
University College Hospital	22.81%	13	26.67	32	9.14%	18
St. Bartholomew's	10.53%	6	11.67	14	9.14%	18
King's College Hospital	8.77%	5	9.17	11	8.12%	16
Guy's	7.02%	4	5.00	6	14.21%	28
The Middlesex	7.02%	4	1.67	2	2.03%	4
St. Thomas's	5.26%	3	3.33	4	4.57%	9
St. Mary's	5.26%	3	3.33	4	3.55%	7
St. George's	5.26%	3	2.5	3	8.63%	17
The London	1.75%	1	5.00	6	5.58%	11
Charing Cross					6.60%	13
Westminster					1.52%	3
REST OF ENGLAND						
Oxbridge	8.77%	5	3.33	4	3.04%	6
Durham College	3.51%	2				
Bristol Medical School			0.83	1	1.01%	2
Liverpool	1.75%	1			0.51%	1
Manchester University Med. College (Owens)			0.83	1		
Royal School Manchester					0.51%	1
Norfolk + Norwich hospital			0.83	1		
Northampton					0.51%	1
Leeds					0.51%	1
Birmingham					0.51%	1
SCOTLAND/IRELAND						
Edinburgh	8.77%	5	7.50	9	9.64%	19
Aberdeen			0.83	1	3.55%	7
Glasgow	1.75%	1	1.67	2	3.55%	7
Ireland	5.26%	3	2.50	3	9.64%	19
EUROPE - UNIVERSITY						
Germany	5.26%	3	6.67	8	1.01%	2
France	15.79%	9	12.50	15	3.55%	7
Austria	3.51%	2	5.00	6	1.01%	2
Amsterdam			0.83	1		
Brussels			0.83	1		
OTHERS			0.83	1 ¹⁷	1.01%	2 ¹⁸
NOT LISTED IN THE DIRECTORY.¹⁹	15.79%	9	8.33	10	11.68%	23

¹⁷ One from the Harley St. Area attended the University of Pennsylvania.

¹⁸ Bombay and Philadelphia.

¹⁹ The medical school attended by medical practitioners is recorded in the *Medical Directory* italics and in parentheses following their qualifications, however, some elect not to return these details.

Table 3.13
Medical Training 1914

Medical Schools	Harley Street %	Harley St. Number	Harley St. Area %	Harley St. Area Number	Greater London %	Greater London Number
LONDON		Population <i>n</i> = 278		Population <i>n</i> = 399		Sample <i>n</i> = 330
St. Bartholomew's	19.06%	53	18.30%	73	12.72%	42
UCH	13.31%	37	14.54%	58	8.18%	27
The London	11.15%	31	11.53%	46	9.70%	32
St. Thomas's	9.71%	27	9.27%	37	7.58%	25
Guy's	8.27%	23	10.03%	40	6.66%	22
The Middlesex	5.76%	16	6.01%	24	3.63%	12
King's College Hospital	5.76%	16	7.52%	30	4.84%	16
St. Mary's	4.68%	13	7.52%	30	5.15%	17
Charing Cross	4.68%	13	4.01%	16	3.33%	11
Westminster	2.16%	6	3.01%	12	1.82%	6
St. George's	1.80%	5	4.51%	18	4.24%	14
REST OF ENGLAND						
Oxbridge	16.55%	46	21.30%	85	10%	33
Manchester University Med. College (Owens)	1.44%	4	1.25%	5	0.90%	3
Durham College	1.08%	3	1.50%	6	2.12%	7
Birmingham University (Queen's)	0.72%	2	0.50%	2	0.30%	1
Yorkshire College	0.72%	2				
Bristol Medical School	0.72%	2	1.00%	4	0.61%	2
Liverpool	0.36%	1	1.25%	5	1.82%	6
Manchester Royal Infirmary	0.36%	1				
Newcastle on Tyne			0.75%	3	0.61%	2
Sheffield			0.25%	1	0.61%	2
Leeds			0.50%	2	0.90%	3
SCOTLAND/IRELAND						
Edinburgh	15.83%	44	9.77%	39	13.33%	44
Glasgow	5.76%	16	1.25%	5	3.94%	13
Aberdeen	3.24%	9	2.01%	8	4.54%	15
Ireland	5.04%	14	2.76%	11	9.09%	30
Wales			0.25%	1	0.90%	3
EUROPE - UNIVERSITIES						
Germany	16.19%	45	10.78%	43	3.03%	10
Switzerland	10.07%	28	1.00%	4		
France	8.99%	25	8.27%	33	2.72%	9
Belgium	1.44%	4	1.25%	5	1.52%	5
Italy	1.08%	3	1.00%	4		
Austria	0.36%	1	9.27%	37	2.42%	8

Medical Schools	Harley Street %	Harley St. Number	Harley St. Area %	Harley St. Area Number	Greater London %	Greater London Number
OTHERS ²⁰	0.75%	3	0.25%	1	0.61%	2
Outside Europe						
Canada and USA	1.75%	7	1.75%	7	0.61%	2
Australia and New Zealand	0.75%	3	0.50%	2	0.61%	2
India ²¹					1.52%	5
NOT LISTED IN THE DIRECTORY	1.75%	7	0.25%	1	3.03%	10

²⁰ One from Copenhagen, Prague and Madrid for Harley Street. One from Prague, Cracow and Sweden for the Harley Street Area. One from Prague and Bucharest for Greater London.

²¹ Three from Bombay, one from Calcutta and Madras, for Greater London.

APPENDIX D

Table 4.1 Hospital Posts
Harley St. Medical Men 1845-1914

Hospital	% on arrival in Harley St.	Number at arrival	%at departure from Harley St.	Number at departure
No hospital attachments	31.05%	204	9.89%	65
Teaching Hospitals				
St. Bartholomew's	4.72%	31	6.54%	43
Middlesex	3.50%	23	5.63%	37
The London	3.50%	23	4.57%	30
UCH	2.59%	17	3.96%	26
St. Mary's	2.74%	18	3.65%	24
King's College	2.44%	16	3.50%	23
St. Thomas's	2.44%	16	3.35%	22
Charing Cross	2.28%	15	3.04%	20
Guy's	1.52%	10	2.13%	14
St. George's	1.52%	10	1.83%	12
Westminster	1.99%	13	1.67%	11
Royal Free	1.83%	12	0.91%	6
Other Hospitals				
Royal London Ophthalmic, Moorfields	4.26%	28	3.65%	24
Gt. Ormond St. (for Sick Children)	2.89%	19	3.35%	22
Seamen's Hospital, Greenwich	2.28%	15	2.89%	19
Great Northern Central, Holloway rd.	1.99%	13	2.73%	18
National Hospital (Paralysis), Queen's Sq.	1.22%	8	2.73%	18
West London Hospital, Hammersmith rd.	3.04%	20	2.59%	17
Mount Vernon Hospital, Middlesex			2.43%	16
Brompton (Consumption), Fulham rd.	1.07%	7	1.98%	13
Evelina Children's Hospital, Southwark	1.37%	9	1.67%	11
Metropolitan, Ear Nose and Throat Hospital	1.22%	8	1.67%	11
Diseases of the Throat & Chest, Golden Sq.	2.28%	15	1.52%	10
Victoria (for Sick Children), Chelsea	1.83%	12	1.52%	10
Hospital for Throat & Ear, Gray's Inn rd.	0.91%	6	1.37%	9
Paddington Green Children's Hospital	1.22%	8	1.22%	8
Western Ophthalmic Hospital, Marylebone			1.22%	8
East London (for Children and Women) ¹	1.37%	9	1.07%	7
Royal Ear, Soho Square	0.91%	6	1.07%	7
Central London Ophthalmic, Judd St.	1.37%	9	0.91%	6
Central London Throat, Nose and Ear	1.07%	7	0.91%	6
City of London (Diseases of the Chest),	0.91%	6	0.91%	6

¹ The Hospital was for children and there was a dispensary for women.

Hospital	% on arrival in Harley St.	Number at arrival	%at departure from Harley St.	Number at departure
Royal Westminster Ophthalmic, King St.	1.07%	7	0.91%	6
Prince of Wales General, Tottenham			0.91%	6
St. John's Hospital, Lewisham			0.91%	6
Bromley Cottage Hospital			0.91%	6
London Hospital for Diseases of the Skin ²			0.91%	6
National Orthopedic Hospital ³			0.91%	6
National Hospital for Diseases of the Heart ⁴			0.91%	6
West End (Nervous diseases), Cavendish Sq.	1.37%	9		
New Hospital for Women, Euston rd ⁵	1.22%	8		
Queen's Hospital for Children, Hackney rd ⁶	0.91%	6		
St. Peter's, Stone & Other Urinary Disease ⁷	0.91%	6		

² Blackfriars Road, SE 1.

³ Great Portland Street.

⁴ Westmorland Street, W1.

⁵ This superseded St Mary's Dispensary for Women established by Elizabeth Garrett Anderson in 1866.

⁶ Late North-Eastern Hospital for children.

⁷ Henrietta Street, Covent Garden

Table 4.2

Special Areas of Medicine or Surgery Practiced by Harley Street Men

Area of Expertise	Specialists Percentage	Specialists Number	Special Interest Percentage	Special Interest Number
Diseases of the eye, Ophthalmology	7.31%	48	1.22%	8
Dental Surgery	3.50%	23		
Obstetrics	3.20%	21	0.30%	2
Diseases of the skin, Dermatology	2.89%	19	0.91%	6
Ear, Nose and Throat (ENT)	2.28%	15	0.76%	5
Diseases of the nervous system, Neurology	2.13%	14		
Aural Surgery	1.98%	13	0.46%	3
Laryngology	1.52%	10	1.37%	9
Mental Diseases, Lunacy	1.37%	9	0.76%	5
Gynecology	1.22%	9		
Orthopaedics	1.22%	8	0.46%	3
Radiography	1.22%	8	0.15%	1
Anaesthetics	0.91%	6	0.46%	3
Pathology	0.76%	5	1.22%	8
Diseases of children, Paediatrics	0.61%	4	1.37%	9
Electro-therapeutics	0.61%	4	0.15%	1
Obstetrics and Gynaecology	0.61%	4		
Disease of urinary tract, Urology	0.46%	3	0.46%	3
Hygiene and Public Health	0.46%	3	0.15%	1
Bacteriology	0.30%	2	0.15%	1
Diseases of the Heart, Cardiology	0.30%	2	1.52%	10
Diseases of the Chest	0.30%	2	1.06%	7
Physiology	0.30%	2		
Respiratory Diseases	0.30%	2	1.22%	8
Pathology and Bacteriology	0.15%	1	0.15%	1
Rare Diseases	0.15%	1	0.15%	1
Tropical Diseases	0.15%	1	0.15%	1
Manipulative Surgery	0.15%	1		
Obstetrics and Paediatrics			0.15%	1
Other Combined Interests ⁸			1.98%	13
Other Interests ⁹			0.91%	6
Total	36.20%	238	18.25%	116

⁸ Combined interests included balneology and climatology, pharmacology and therapeutics, physiology and histology, dermatology and neurology, pathology and paediatrics and dermatology and tropical diseases.

⁹ These included diseases of the digestive system, hydrology, rectal surgery and venereal diseases.

Table 4.3
Hospital Posts, 1845

Medical Staff	Harley Street %	Harley Street Number	Harley St. Area %	Harley Street Area Number	Greater London %	Greater London Number
TEACHING HOSPITALS		Population <i>n</i> = 8		Population <i>n</i> = 19		Sample <i>n</i> = 101
Consulting surgeon	12.50%	1	5.26%	1		
Physician			36.84%	7	1.98%	2
Surgeon			5.26%	1	1.98%	2
Assistant physician					1.98%	2
Assistant surgeon			5.26%	1		
OTHER HOSPITALS						
Consulting physician			5.26%	1		
Consulting surgeon					0.99%	1
Physician	25.00%	2			3.96%	4
Surgeon	12.50%	1	5.26%	1	8.91%	9
Assistant physician					0.99%	1
Assistant surgeon			5.26%	1	0.99%	1
Former Staff Post						
No Staff Post	50.00%	4	31.58%	6	78.22%	79
Total		8		19		101

Table 4.4
Hospital Posts, 1880

Medical Staff	Harley Street %	Harley Street Number	Harley St. Area %	Harley Street Area Number	Greater London %	Greater London Number
TEACHING HOSPITALS		Population <i>n</i> = 57		Population <i>n</i> = 120		Sample <i>n</i> = 197
RETIRED						
Consulting physician	10.53%	6	5.83%	7	1.02%	2
Consulting surgeon	5.26%	3	3.33%	4		
SENIOR MEDICAL STAFF						
Physician	15.79%	9	6.67%	8	2.54%	5
Surgeon	8.77%	5	3.33%	4	2.03%	4
Assistant physician	1.75%	1	6.67%	8	1.02%	2
Assistant surgeon	3.51%	2	6.67%	8	0.51%	1
JUNIOR MEDICAL STAFF						
House physician					2.03%	4
House surgeon	1.75%	1			2.03%	4
SPECIAL DEPARTMENTS	1.75%	1				
Obstetrician - physician			0.83%	1		
Chloroformist			0.83%	1	0.51%	1
Ophthalmic surgeon			1.67%	2		
Throat/Ear/Nose surgeon			0.83%	1		
Dental surgeon			0.83%	1	1.02%	2
Assistant - special wards					1.02%	2
OTHER HOSPITALS						
RETIRED						
Consulting Physician	10.53%	6			1.02%	2
Consulting Surgeon	1.75%	1	0.83%	1	0.51%	1
SENIOR MEDICAL STAFF						
Physician	8.77%	5	11.67%	14	0.51%	1
Surgeon	10.53%	6	7.50%	9	2.03%	4
Assistant Physician	1.75%	1	4.17%	5		
Assistant Surgeon			3.33%	4	1.02%	2
JUNIOR MEDICAL STAFF						
Medical officer			1.67%	2		
Assistant medical officer					0.51%	1
Assistant - special wards					1.02%	2
SPECIAL DEPARTMENTS						
Dental surgeons			0.83%	1		

Medical Staff	Harley Street %	Harley Street Number	Harley St. Area %	Harley Street Area Number	Greater London %	Greater London Number
NURSING HOMES/ COTTAGE HOSPITALS						
Consulting surgeon					0.51%	1
Physician					1.02%	2
Surgeon	1.75%	1	0.83%	1	3.55%	7
Medical officer					6.60%	13
Medical assistant					1.02%	2
Former Staff Post	8.77%	5	14.17%	17	22.84%	45
NO STAFF POST	7.02%	4	17.50%	21	44.16%	87
Total	100%	57	100%	120	100%	197

Table 4.5
Hospital Posts, 1914

Medical Staff	Harley Street %	Harley Street Number	Harley St. Area %	Harley Street Area Number	Greater London %	Greater London Number
TEACHING HOSPITALS		Population <i>n</i> = 278		Population <i>n</i> = 399		Sample <i>n</i> = 330
RETIRED						
Consulting physician	5.04%	14	1.50%	6		
Consulting surgeon	8.27%	23	1.50%	6	0.61%	2
SENIOR MEDICAL STAFF						
Physician	5.04%	14	5.51%	22	0.61%	2
Surgeon	5.04%	14	2.76%	11		
Assistant physician	1.08%	3	2.26%	9		
Assistant surgeon	2.52%	7	2.50%	10		
JUNIOR MEDICAL STAFF						
House physician	0.72%	2	2.26%	9	1.52%	5
House surgeon	1.44%	4	1.50%	6	0.61%	2
Physician out-patients	0.36%	1	1.50%	6		
Surgeon out-patients	0.36%	1	1.00%	4		
Registrar	1.08%	3	1.50%	6	0.61%	2
SPECIAL DEPARTMENTS						
Surgeon or physician accoucher/ obstetrician/gynaecologist	0.36%	4	3.26%	13		
Anaesthetist	0.36%	1	2.51%	10		
Dental surgeons	1.44%	4	1.25%	5	0.61%	2
Skin surgeons, physicians	0.36%	1	1.25%	5	0.30%	1
Ophthalmic surgeon	1.44%	4	2.26%	9		
Electro-therapists/radiographer	1.44%	4	1.25%	5		
Neurology/ nervous diseases	0.36%	1	0.25%	1		
Mental specialist			0.75%	3		
Orthopaedic surgeon	0.72%	2	0.25%	1		
Genito-urinary surgeon			0.25%	1		
Throat/Ear/Nose surgeon	1.44%	4	0.50%	2		
Pathologist/Bacterologist	1.08%	3	0.25%	1		
Children/paediatrics			0.50%	2		
Assistant in special wards	3.24%	9	2.76%	11	1.21%	4
OTHER HOSPITALS						
RETIRED						
Consulting Physician	4.67%	13	3.26%	13	1.52%	5
Consulting Surgeon	10.79%	30	3.51%	14	0.61%	2

Medical Staff	Harley Street %	Harley Street Number	Harley St. Area %	Harley Street Area Number	Greater London %	Greater London Number
SENIOR MEDICAL STAFF						
Physician	6.83%	19	6.27%	25	1.82%	6
Surgeon	7.19%	20	11.78%	47	2.42%	8
Assistant physician	0.72%	2	1.00%	4		
Assistant surgeon	0.72%	2	3.00%	12		
JUNIOR MEDICAL STAFF						
House physician	0.72%	2	0.25%	1	0.30%	1
House surgeon	0.36%	1	1.25%	5	2.42%	8
Medical officer					5.15%	17
Assistant medical officer					2.12%	7
Physician out-patients			1.00%	4		
Surgeon out-patients			0.50%	2		
Registrar	0.36%	1				
SPECIAL DEPARTMENTS						
Anaesthetist			1.00%	4	1.21%	4
Dental surgeons	0.72%	2				
Electro-therapists/ radiographer	0.36%	1				
Obstetrics/gynaecology			0.25%	1		
Orthopaedic surgeon	0.36%	1				
Skin surgeons, physicians	0.36%	1				
Throat/Ear/Nose surgeon	0.36%	1				
Ophthalmic Surgeon	1.44%	4	0.50%	2	0.30%	1
Pathologist/Bacterologist	1.08%	3	1.50%	6		
Assistant in special wards	1.08%	3	0.75%	3	0.30%	1
NURSING HOMES/DISPENSARIES COTTAGE HOSPITALS						
Consulting physician	0.36%	1			1.21%	4
Consulting surgeon	0.36%	1	0.50%	2	0.61%	2
Surgeon	0.36%	1				
Former Staff Post	10.79%	30	10.53%	42	35.76%	118
No Staff Post	5.76%	16	12.03%	48	38.18%	126
Total	100%	278	100%	399	100%	330

Table 4.6
Teaching Posts

Year	Harley Street Percentage	Harley Street Number	Harley St. Area Percentage	Harley St. Area Number	Greater London Percentage	Greater London Number
1845	37.50%	3	42.11%	8	5.94%	6
Formerly	12.50%	1	5.26%	1	0%	0
No Post	50.00%	4	52.63%	10	94.06%	95
1880	36.84%	21	20%	24	3.55%	7
Formerly	19.30%	11	22.50%	27	6.09%	12
No Post	43.86%	25	57.50%	69	90.36%	178
1914	46.04%	128	27.57%	110	3.03%	10
Formerly	16.19%	45	7.27%	29	1.82%	6
No Post	46.76%	130	65.16%	260	95.15%	314

APPENDIX E

Table 5.1

Summary of medical and learned society memberships held by Harley Street men – at date of arrival.¹

SOCIETIES WITH 7 OR MORE FELLOWS/MEMBERS FROM HARLEY STREET	FELLOWS	MEMBERS
Medical Society London (1773-extant)	99	
Royal Society of London (1662 – extant)	24	
Hunterian Society (1819-extant)	14	
Linnaean Society (1788-extant)	12	
Zoological Society of London (1826-extant)	7	
British Medical Association (1832-extant)		205
Ophthalmological Society of the UK (1880-extant) ²		47
West London Medico-Chirurgical Society (1892-1936)		48
Harveian Society (1831-extant)		40
Anatomical Society (1887- extant)		17
Physiological Society (1876-extant)		11
Abernethian Society (1832 -extant)		9
Societies which amalgamated with RSM ³		
Royal Society of Medicine (1907-extant)	111	
Royal Medical and Chirurgical Society (1805-1907)	128	
Pathological Society (1846-1907)	9	108
Obstetrical Society London (1859 –1907)	25	
British Gynaecological Society (1884-1907)	9	
Clinical Society (1868-1907, after RSM)		85
Neurological Society (1886-1907, after RSM)		17
Society for Study of Diseases in Children (1900 – 1908)		12
Laryngological Society of London (1893 –1907)		10
Dermatological Society of London (1882-1907)		8

¹ The only include societies based in London or with a London branch. A few of the cohort were members of societies outside London such as the Medical Society of Edinburgh, which was established in 1737 and had 7 members from Harley Street. The neurologist, Samuel Kinnear Wilson was the society's President from 1902-03 before he moved to Harley Street in 1914. For the aims and organisation of the society see, Jacqueline Jenkinson, *Scottish Medical Societies: 1731-1939, their History and Records*, (Edinburgh, 1933).

² The Ophthalmological Society of the United Kingdom became the Royal College of Ophthalmologists in 1988. Hunting, *History of the RSM*, pp. 333-4.

³ For a list of the societies that merged, see Davidson, *The Realisation of an Ideal*, pp. 36-7. Five new associations had merged with the RSM by 1914, see Hunting, *History of the RSM*, pp. 171, 213 and 301.

APPENDIX F

Table 7.1

The number of women medical practitioners in the UK, London and the percentage in Harley Street

Year	Total number of registered medical women	Number in London and the Suburbs.	Number of registered women in Harley Street.	Percentage of registered women in Harley Street.
1889	70	25	1	4%
1894	166	41	2	5%
1899	387	85	3	4%
1904	648 ¹	124	7	6%
1909	842	184	13	7%
1914	1,000 ²	243 ³	16	7%

Source: - *The Englishwoman's Year-Book* and the Database

¹ In 1899, 29 women were 'not placed' and these have been included in the above data, the exact total may therefore be lower as some of these women may have retired from practice or died. The figure for 1904 includes those whose addresses were not known to the editor of L.M.H., *Year-Book*, also those who could not be 'placed.' In 1909, the addresses of 'more than 20 medical women' could not be found, I have added 20 to the count for the purposes of numerical consistency the total number therefore may be slightly higher than I have calculated.

² Figure from Carol Dyhouse, 'Driving Ambitions: Women in Pursuit of a Medical Education, 1890-1939' *Women's History Review* Vol. 7, No. 3, 1998, p. 321.

³ Own count from J&A Churchill, *The London and Provincial Medical Directory for England and Wales*, (London), Vol. 1914.

Table 7.2

Women Medical Practitioners registered in Harley Street, 1888 - 1914.

Generation	Surname	Maiden Name	First Names	Date of arrival	Last year	Total years	Age on arrival	Year of death if in Harley St
1st	Scharlieb	Bird	Mary Ann Dacomb	1888	1924 ⁴	37	43	
2nd	Boyd	Toms	Florence Nightingale	1891	1910	20	36	1910
2nd	Chadburn	N/A	Maud Mary	1899	1946	48	31	
2nd	Chesney	N/A	Lilian Mary	1902	1907	6	33	
1st	Walker	N/A	Janet Harriet	1902	1938	37	39	1938
2nd	Hawthorne	N/A	Janie Lorimer	1904	1945	41	31	1945
2nd	Scharlieb	N/A	Mary Ethel Sim	1904	1926	23	34	1926
2nd	Anderson	N/A	Louisa Garrett	1905	1913	9	32	
2nd	Thorne	N/A	May	1905	1914 ⁵	10	44	
1st	Ellaby	N/A	Charlotte Louisa	1906	1909	4	52	1909
2nd	Harman	Chamberlain	Katherine	1906	1914 ⁶	9	35	
2nd	De Steiger	N/A	Adele Isabella	1907	1909	3	Not known	
2nd	Stoney	N/A	Florence Ada	1907	1910	4	37	
2nd	Taylor	N/A	Mary Flint	1907	1907	1	30	
2nd	Gordon	N/A	Mary Louisa	1908	1912	5	46	
2nd	Savill	Blackadder	Agnes Forbes	1908	1915	8	33	
2nd	Vaughan-Sawyer	Vaughan	Ethel May	1909	1949 ⁷	41	41	
2nd	Flemming	Wood	Emily Elizabeth	1911	1928	18	48	
2nd	Hamilton	N/A	Dyddgu	1911	1932	22	45	

⁴ Scharlieb's house in Harley Street was demolished in 1924, she then moved in with her son in Regent's Park. Jane Walker, 'Dame Mary Scharlieb' *BMJ*, Nov. 29, 1930, p. 937.

⁵ Anon, 'May Thorne', *BMJ*, Nov. 3, 1951, p. 1094, Thorne retired from practice in 1914, however *The Medical Directory* dates her retirement as 1921.

⁶ Katherine Harman was registered at her Harley Street address until 1941, but ceased to practice at the start of the war in 1914. She was married to Nathaniel Bishop Harman, a Harley Street consulting ophthalmic surgeon.

⁷ Vaughan-Sawyer retired from practice in 1949 at her Harley Street address.

Generation	Surname	Maiden Name	First Names	Date of arrival	Last year	Total years	Age on arrival	Year of death if in Harley St
2nd	Davies-Colley	N/A	Eleanor	1912	1934	22	38	1934
2nd	Mecredy	N/A	Emily Mary Spencer	1912	1938	27	33	
2nd	Addison	Brown	Kate	1914	1938	25	40	
2nd	Alstrom	N/A	Hedda	1914	1925	12	52	
2nd	Briscoe	Stagg	Grace Maud	1914	1936	23	33	

Notes

1. The surnames of the first generation are in bold. The sources for Table 7.2 , were as follows: *The Medical Directory*, vols. 1888-1914, *Medical Register*, vols. 1888-1914, *Who's Who*, 1888-1914, application forms from the archives of the Royal Free Hospital, General Council Register Glasgow University, General Council Register University of Edinburgh, and obituaries. Clara Violet Kelynack, née McLaren is in *The Medical Directory* from 1908 to 1909 as practicing in Harley Street, however, she did not practice medicine following her marriage to Theo. N. Kelynack in 1904. See *Medical Woman's Journal*, 47, Nov. 1940, pp. 341-342. Kelynack did not, however, completely withdraw from the medical arena. She was a supporter of medicine as a profession for women and for 20 years was the secretary to the Medical Women's Federation. See *Medical Woman's Journal*, 47, Nov. 1940, pp. 341-342. As the database only contains details of the cohorts who 'practised' medicine in Harley Street and as Violet Kelynack did not, she has been excluded from this data. This is also the case with Anne Francis Evans née Piercy, who also did not practice
2. The date of arrival in Harley Street is the date of registration in the Street according to *The Medical Directory*. There may be some cases where the medical practitioner arrived during the course of the previous year, though not registered at their Harley Street address until the beginning of the new year. To be consistent, I have kept the date of arrival as that maintained by *The Medical Directory*. For example, see Anna and Michael Smith *Dr Jane Walker and her Hospital*, (Suffolk, no date, but probably 20th Century), p. 55. According to the authors, Dr Walker moved to Harley Street in 1901, though *The Medical Directory* records her arrival there as after 1902.

Table 7.3

Medical Schools attended by female medical practitioners in Harley Street

Medical School (Primary medical qualification, MB, BS or LSA) ⁸	PERIOD - FROM DATE OF ARRIVAL IN HARLEY STREET				
	Year Women admitted	1888- 1894	1895- 1904	1905- 1914	Grand Total
Medical College for Women Edinburgh ⁹	1889		1		1
London Medical School for Women (L.M.S.W.)	1874	2	3	15	20
Glasgow School of Medicine for Women (Queen Margaret College) ¹⁰	1890		1	1	2
University of Paris	1867 ¹¹			1	1
Grand Total		2	5	17	24

Source: *Medical Directory*, Scharlieb, Appendix 'Women in the Medical Profession' and Obituaries.

⁸ M. Scharlieb did part of her training at Madras Medical School and received a diploma, however she attended the LSMW in 1878 and took the MB and BS (London University) in 1882. She also attended the University of Vienna. Jane Walker also attended the University of Vienna and Hedda Alstom attended the University of Durham.

⁹ The school amalgamated with the men's extra-mural college in 1909.

¹⁰ Queen Margaret College, Glasgow was founded in 1889 its medical school opened in 1890. Through a deed of incorporation in 1895, the College changed its name to the women's department of the University of Glasgow. Alexander, *First Ladies of Medicine*, pp. 5-6.

¹¹ Blake, *The Charge of the Parasols: Women's Entry to the Medical Profession*, p. 207.

Table 7.4

Hospital and other medical posts held by Female Medical Practitioners in
Harley Street

HOSPITAL	1888-1894	1895-1904	1905-1914	Total
Belgrave Hospital for Children (Incorporated)			1	1
Blackfriars Skin Hospital			1	1
East London Children's Hospital Shadwell	1			1
East Anglian Sanatorium for Consumption		1		1
Essex County Asylum, Brentwood			1	1
Evelina Hospital for Sick Children			1	1
Mission Hospital for Women and Children, Canning Town ¹²			1	1
New Hospital for Women, Euston rd.	1	2	5	8
Royal Free Hospital		1	5	6
St. John's Hospital for Diseases of the Skin (Incorp.)			2	2
No current hospital attachments on date of arrival	1	3	7	11

Source: - Database

¹² The Mission Hospital for Women and Children in Canning (1900) arose out of the expansion of the Canning Town Women's Settlement Dispensary, which had been set up in 1891, Bell, *Storming the Citadel*, p. 147.

Table 7.5
Membership of Medical Societies

SOCIETY MEMBERSHIP. ¹³	YEAR OF FOUNDATION.	YEAR WOMEN FIRST ADMITTED.	NUMBER FROM HARLEY STREET.	HARLEY STREET. %
Association of Registered Medical Women	1879	1879	8	33.3%
British Medical Association	1832	1873/4 ¹⁴	6	25.00%
Medico-Psychological Association	1841	1888	1	4.16%
Obstetrical Society of London	1858	1902	2	8.30%
Röntgen Society ¹⁵	1897	1897	1	4.16%
Royal Society of Medicine	1907	1907	1	4.16%
Society for Study of Inebriety ¹⁶	1884	1884	1	4.16%
Society of Anesthetists	1893	1894	1	4.16%
Therapeutical Society	1902	1902	1	4.16%
No Society Memberships Listed ¹⁷	N/A	N/A	8	33.3%

¹³ The participants were all members and there was one fellow of the Royal Society of Medicine and one fellow of the Obstetrical Society of London.

¹⁴ Garrett Anderson was the only woman member of the BMA until the exclusion clause was removed in 1892. Louisa Garrett Anderson, *Elizabeth Garrett Anderson*, p. 262.

¹⁵ The Society was named in honour of Wilhelm Conrad Röntgen (1845-1923) who discovered the first x-ray in 1895.

¹⁶ The Society, which, was based in 133 Harley Street, studied the cause and effects of alcoholism.

¹⁷ *The Medical Directory* did not reflect the true total of society memberships, for example Mrs Addison, Dr Alström and Miss Mecredy were all members of the Association of Registered Medical Women in 1913-1914; they did not, however, return these memberships to *The Medical Directory*. See, Wellcome, 'List of Members' 1913 – 1914 archives of the Association of Registered Medical Women, MWF/C.74

Table 7.6

Additional Society Memberships Acquired at Date of Departure from Harley Street

SOCIETY MEMBERSHIP	YEAR OF FOUNDATION.	YEAR WOMEN FIRST ADMITTED.	NUMBER FROM HARLEY STREET.	PERCENTAGE %
Royal Society of Medicine	1907	1907	10	41.67
British Medical Association	1832	1873/4	5	20.83
Medical Women's Federation	1917	1917	4	16.7
Association of Registered Medical Women	1879	1879	3	12.5
Physiological Society	1876	1915	1	4.16
Pathological Society of Great Britain and Ireland ¹⁸	1906	1906	1	4.16
Obstetric & Gynecological Society London	1929	1929	1	4.16
Association of Surgeons Great Britain	1920	1920	1	4.16

¹⁸ This society, which was established in the University of Manchester, is not the same as the Pathological Society in London (1846 – 1907).

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Photo of Dr Jane Harriet Walker's portrait from the archives of the Royal Free Hospital. The original painted in 1921 by Wilfred Gabriel De Glehn M.R.A., hangs in the member's common room of the Royal Society of Medicine.

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